ABSTRACT

WHITNEY M. YOUNG, JR., SCHOOL OF SOCIAL WORK

WALKER, ONDRA A. B.S.W. GEORGIA STATE UNIVERSITY, 2012

M.S.W. CLARK ATLANTA UNIVERSITY, 2013

A STUDY OF THE PREVALENCE OF RACE-RELATED POST TRAUMATIC STRESS DISORDER EXPERIENCES, ACCESS TO TREAMENT, AND IMPACT ON ACADEMIC ACHIEVEMENT AMONG AFRICAN-AMERICAN COLLEGE STUDENTS

Committee Chair: Richard Lyle, Ph.D.

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Racial encounters can be direct, subtle, or ambiguous. They can occur on an interpersonal level or be the effect of systematic acts. Current and prospective African-American college students across the United States are constantly and consistently deprived of a quality education due to inadequate mental health care to address the horrific and insidious effects of post traumatic stress disorder (PTSD). The purpose of this study was to examine the relationship between race-based trauma and PTSD among African Americans and to explore stressors related to PTSD. Participants in the study were African-American college students residing in the Metropolitan Atlanta area. Quantitative and qualitative research methodologies were both applied to the study in order to answer the research questions. The results have shown that there was a gender difference in perceiving the race-related trauma; household income level also negatively

relates to the degree of trauma experienced by participants. On the other hand, academic performance and the willingness to seek counseling were not affected. For the qualitative aspect of the study, most participants reported that although they did not personality experience race-related trauma, it is understood that it happens to others. Findings in the present study suggested that African-American students may not be aware of cultural bias against mental health professionals but may nevertheless underutilize counseling services when a legitimate need exists. It is therefore recommended that college counselors who serve African-American students conduct outreach work to familiarize these students with race-related trauma and its potential effects, to counteract a pervasive delegitimization of valid and potentially disruptive experiences that may prevent students from seeking the help they need. In addition to conducting informational and awareness-raising outreach, it is imperative that mental health professionals address the need for culturally sensitive care.

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ONDRA ANTON WALKER

WHITNEY M. YOUNG, JR., SCHOOL OF SOCIAL WORK

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TABLE OF CONTENTS

LIST OF TABLES

Table

Table

CHAPTER I

INTRODUCTION

This study will add to the social work body of knowledge regarding the need to recognize raced-based trauma as a legitimate stress disorder among African-American college students who have experienced racial discrimination and harassment. It will draw greater attention to the need for more culturally sensitive training among professionals as well as more culturally sensitive treatment interventions. The results of this study reveal the need for more research on policy changes.

Stress is defined as "a person–environment, biopsychosocial interaction, wherein environmental events (stressors) are appraised first as either positive or unwanted and negative" (Carter, 2007, p. 18). When an unwanted or negative stressor exceeds one's perceived ability to cope or adapt, one experiences stress reactions. Trauma is a form of stress and creates a multitude of effects at the psychosocial, biological, spiritual, and political levels. Events that evoke very high levels of stress traumatize almost everyone, but whether traumatization occurs following events at lower levels of stress depends on a variety of biopsychosocial factors (Lazarus, 1993). Although trauma is a form of stress, it is important to clarify the difference between the two constructs.

Trauma is a subset of stressors that involve exposure to actual or threatened death, serious injury, or sexual violence and can take place in one or more of the following ways: (a) directly experiencing the traumatic event(s); (b) witnessing in person the

event(s) as it occurred to others; (c) learning that the traumatic event(s) occurred to a close family member or close friend and, in cases of actual/threatened death of a friend or family member, the event(s) must have been violent or accidental; and (d) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (American Psychiatric Association, 2013).

In some cases, traumatic events lead to the development of posttraumatic stress disorder (PTSD). According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*; American Psychiatric Association, 2013), PTSD involves the development of symptoms such as intrusions, avoidance, negative changes in mood and thinking, and hyperarousal after exposure to a traumatic event. Furthermore, these symptoms are often accompanied by other complications, such as depression, substance abuse, relationship problems, and physical symptoms (Sanders-Phillips, Kliewer, Tirmazi, Nebbitt, Carter, & Key, 2014).

The consequences of PTSD extend far beyond the individual who develops the disorder after experiencing trauma. Disruptions in family relationships are common following onset of PTSD, in addition to heightened psychological distress in the partners and family members of people with this disorder. Parental PTSD can have numerous negative implications for children and is associated with mental health problems, poor psychosocial adjustment, and academic difficulties in offspring. Intergenerational transmission of trauma exposure and PTSD have been documented in numerous studies, indicating that parental PTSD is associated with greater exposure to trauma and heightened risk of developing PTSD in offspring.

The widespread and substandard scholastic attainment of African-American students in the United States is an ongoing and unresolved concern for counselors and educators (Orfield, Losen, Wald, & Swanson, 2004), and the disproportionate underachievement of this student population is evident in a multitude of educational measures, including scores on national achievement tests (Cartledge & Robinson-Ervin, 2016), graduation rates (Orfield et al., 2004), and placement in low-ability special education programs (Civil Rights Project at Harvard University, 2002). Efforts to address academic underachievement have traditionally conceptualized underperformance as the result of a child's personal or cultural deficits (Ford, Harris, Tyson, & Trotman, 2002; Wycoff, 1996), and educators have long ascribed common symptoms of traumatic stress such as exaggerated startle responses, flat affect or diminished interest, withdrawing from peers, and thoughts or feelings that disrupt normal activities to these perceived deficits (Elliott, 1997; Graham-Bermann & Levendosky, 1998). While deficit-oriented views work to further exacerbate underperformance (Goings, 2016), traumatic stress theory explains the effects that ecosystemic factors such as hegemony, the dominance of one social group over another, may have on an individual's functioning (Carlson, 1997; Carter, 2007).

Scholarship on hegemony and traumatic stress exposes the many barriers that African-American individuals face in society by demonstrating the mental and physical health effects of discrimination (Goodman & Frazier, 2015). Researchers in this area have focused on the coping strategies used by many African Americans and members of other ethnic groups who have been historically marginalized in the United States (Utsey,

Ponterotto, Reynolds, & Cancelli, 2000). Resilience, the mental tactics that individuals use to cope with and overcome barriers and oppression, is often transmitted intergenerationally among marginalized populations (Leary, 2005). Nevertheless, widely used coping strategies cannot completely counteract the prevalence of hegemony-fueled PTSD among African-American students, who face little-studied yet extensive obstacles when they try to obtain medical care for their trauma.

There is currently a dearth of research on the barriers that the African-American population, particularly African-American college students, faces in seeking comprehensive treatment for PTSD. Limitations in policy result in African-American students of all ages receiving inadequate health care services for psychological issues, and this failure to provide appropriate mental health care might partially explain the achievement gap between African-American and white students. As culturally competent practitioners and social justice advocates, counselors can play a central role in promoting coping resilience by addressing systemic causes of traumatic stress. African-American college students deserve the opportunity to receive a formal education at an optimal level, albeit at a historically black college or university (HBCU) or a predominantly white institution (PWI).

Because the development of PTSD is conditional on exposure to trauma, PTSD may be the most preventable of mental disorders. In their treatment of members of socially marginalized groups, counselors must assess traumatic stress experiences using a framework that includes individual perception as well as contextual issues (Post et al., 2017). Carlson (1997) defined traumatic stress experiences as events that are perceived as

negative, sudden, and uncontrollable; such experiences may be moderated by the severity of the trauma and by the individual's social context, life events, developmental level, and biological factors. These aspects are important in the discussion of trauma among students from socially marginalized groups or societies that have historically experienced sociopolitical oppression because oppression is likely to be an ongoing part of social context. Indeed, researchers have noted that socially marginalized individuals have a higher risk of developing trauma-related symptoms (Breslau et al., 1998).

We have the unique opportunity to reduce the burden of PTSD within the African-American community both by preventing trauma exposure and by delivering timely interventions in the wake of trauma to those most at risk by way of policy. Understanding mental health disorders such as PTSD is critical, as it relates to promoting solutions. Effective public policies can help to shape societal norms concerning public health issues. Ideally, policies are informed by evidence, and the development and implementation of sound and timely public policies are essential in addressing trauma as a global public health concern. Such policies must focus on preventing traumatic events, when possible; providing early intervention services for survivor communities at risk of poor post-trauma outcomes; and reducing stigma. Additionally, it is important that policymakers recognize that PTSD is not exclusively a military-related phenomenon and that attention and support are needed for research and policies that address PTSD stemming from all types of trauma.

While many countries have made strides in developing public policies aimed at preventing or intervening in the aftermath of trauma, much work remains to be done

around the world. There are currently several overarching mental health policy challenges facing communities and countries plagued by violence and trauma. Further, mental health resources are often inequitably distributed among countries, regions, and within communities. These inconsistencies in access, use, and outcomes of care vary by geographic region, race and ethnicity, gender, sexual orientation, and socioeconomic status. For example, populations with low socioeconomic status have the highest need for and the poorest access to mental health care (Villatoro, Mays, Ponce, & Aneshensel, 2017). Evidence suggests that most mental health resources are located in or near large cities, and many of these resources are heavily focused on institutional care rather than community-based care (Saracena et al., 2007). In order to adequately address mental health and trauma focused prevention and early intervention, governments must invest more of their health budgets in mental health and trauma-informed services and infrastructure, and they must also ensure equitable distribution of these resources, especially among those at greatest risk for trauma exposure and poorer post-trauma outcomes.

Because much of the global population receives medical treatment only in primary care settings, mental health issues such as PTSD often go undiagnosed. Many efforts are underway to integrate physical and mental health and provide trauma-informed training to health care providers, and notable examples of these efforts fall under the oversight of the Department of Veterans Affairs in the United States and of the governments of multiple European countries. These include a policy of routine screening by health care providers for trauma exposure and resources to assist providers in

addressing trauma and PTSD in primary care (U.S. Department of Veterans Affairs, 2002). Similar practices and policies are emerging in other nations around the world; however, integration of mental health and trauma-informed services remains the exception and not the rule in many communities.

Statement of the Problem

The *DSM–5* would narrowly define trauma as events that are perceived as life-threatening, whereas other scholars (e.g., Carlson, 1997), especially those drawing on trauma theories to describe racism or other types of relational betrayals (e.g., infidelity in romantic relationships), might include a broader range of existential or relational ruptures. Carter (2007) proposed a non-pathological model of traumatic stress referred to as race-based traumatic stress and injury. Prior to Carter's (2013) measure of race-based traumatic stress, there were no other assessment tools available that documented the traumatic impact of particular encounters with racism. Although researchers have found that racism is related to a range of physical and mental health consequences, other elements are essential for the reactions to be considered traumatic.

Carter's measure differs from other trauma measures in that the event is racially oriented, and the criteria do not draw directly from *DSM–5* criteria for PTSD. Carter defines a racial trauma as an event that evokes emotional or physical pain (or the threat of pain thereof) and that results from racism in forms of racial harassment, racial discrimination, or discriminatory harassment. Other scholars have identified racism as an everyday occurrence (Essed, 1991) and as a constant feature of life for people of color, especially black people (Feagin & McKinney, 2003 Feagin & Sikes, 1994). These

models and typologies of racism uniquely and effectively document the types of trauma-inducing situations that African-American college students face each day of their academic careers and that often repeat across generations.

Racial encounters can be direct, subtle, or ambiguous. They can occur on an interpersonal level or be the effect of systematic acts. Carter (2013) has suggested that for a racial encounter to be traumatic, it must be experienced as sudden, out of one's control, and highly negative. Symptom clusters typically include intrusions, arousal, avoidance, anxiety, anger, depression, low self-esteem, shame, and guilt. Carter's measure is currently the only measure of race-based traumatic stress. Whereas there is utility in using instruments that measure the frequency and stress associated with racial discrimination, it is also important to connect encounters of racism with reactions.

Current and prospective African-American college students across the United States are constantly and consistently deprived of a quality education due to inadequate mental health care to address the horrific and insidious effects of PTSD. Future investigations need to focus on developing a methodology for defining traumatic stress that is appropriate for individuals from a diverse array of cultures. Furthermore, studies using nationally representative data to examine the relationship between traumatic stress symptoms and academic achievement can enhance understanding of ecosystemic factors in education. The use of a nationally representative data set would enable researchers to include the multiple factors of culture, gender, and class on traumatic stress and academic achievement. Examining the influence of discrimination within the construct of traumatic

stress can serve to legitimize individuals' psychological reactions to hegemony (Villatoro, Mays, Ponce, & Aneshensel-Saxena et al., 2017).

Purpose of the Study

The purpose of this study was to examine the relationship between race-based trauma and PTSD among African Americans and to explore stressors related to PTSD. Participants in the study will be African-American college students residing in the Metropolitan Atlanta area.

Racism is a source of trauma that may result in a wide range of mental and physical health consequences (Pieterse, Todd, Neville, & Carter, 2012). Posttraumatic stress disorder is one of the most commonly studied post-trauma psychiatric disorders. Although there is a preponderance of evidence linking racial discrimination to stress and mental health outcomes, there has been a recent theoretical advance introduced by Carter (2007) that conceptualized racism itself as trauma. Researchers in the fields of counseling, psychology, and public health have noted the deleterious influence of hegemony on the mental and physical health of individuals with a broad range of ethnic and cultural backgrounds (Cartledge & Robinson-Ervin, 2016).

As such, systemic oppression may compound transgenerational trauma experienced by socially marginalized individuals because of endemic, long-term hegemony (Goodman & West-Olatunji, 2009). Across multiple studies, researchers have linked discrimination to psychological distress for socially marginalized individuals (LeBlanc, Frost, & Wight, 2015). For instance, depression and low self-esteem may affect African Americans as an outcome of historical oppression (Leary, 2005; Vontress,

Woodland, & Epp, 2007). As a nation, the United States still exhibit traits of systemic oppression, and this could lead to transgenerational trauma in the African Americans, especially young adults who are in college/university.

Based on the purpose of the study and the research problem of the study, the following research questions are constructed.

Research Questions

RQ1: Is there a statically significant relationship between the occurrences of race-related PTSD and African-American college students?

RQ2: Is there a statistically significant difference between male and female African-American college students in terms of incidences of race-related PTSD?

RQ3. Is there a statistically significant relationship between race-related PTSD and the household income of African-American college students?

RQ4: Is there a statistically significant relationship between race-related PTSD and access to treatment among African-American college students?

RQ5: Is there a statistically significant relationship between race-related PTSD and academic achievement among African-American college students?

Hypotheses

Ho1: There is a statistically significant relationship between the occurrences of race-related PTSD and African-American college students.

Ho2: There is a statistically significant difference between male and female African-American college students in terms of incidences of race-related PTSD.

Ho3: There is a statistically significant relationship between participant household income and the incidences of race-related PTSD.

Ho4: There is a statistically significant relationship between race-related PTSD and access to treatment among African-American college students.

Ho5: There is statistically significant relationship between race-related PTSD and academic achievement among African-American college students.

Terms and Definitions

Race is a social construction that permits the exploitation of one group over another with the development of ideology that justifies it (Dovidio, 2000). It involves myths about populations of people and how they are viewed as naturally or biologically different from other populations (Cokley, 2007).

Racial discrimination can be classified using a tripartite typology, including (a) individual, (b) institutional, and (c) cultural racism (Jones, 1997). *Individual racism* involves racial prejudice, personal stereotypes, and discrimination that create and support disparities between members of different groups. *Institutional racism* refers to the intentional or unintentional manipulation of policies that restrict the opportunities of particular groups of people.

Racial identity refers to "a sense of group or collective identity based on one's perception that he or she shares a common heritage with a particular racial group" (Helms, 1993, p. 3).

Stress is defined as "a person–environment, biopsychosocial interaction, wherein environmental events (stressors) are appraised first as either positive or unwanted and negative" (Carter, 2007, p. 18).

Trauma is a form of stress that creates a multitude of effects at the psychosocial, biological, spiritual, and political level. Events that evoke very high levels of stress traumatize almost everyone, but whether traumatization occurs for events at lower levels of stress depends on a variety of biopsychosocial factors (Lazarus, 1993).

Ethnicity refers to a characterization of a group of people who see themselves and are seen by others as having a common ancestry, shared history, shared traditions, and shared cultural traits such as language, beliefs, values, music, dress, and food (Cokley, 2007). Ethnicity is used interchangeably with race "when the definition of ethnicity includes biophysical traits" (p. 225).

Racial encounters can be direct, subtle, or ambiguous. They can occur on an interpersonal level or be the effect of systematic acts. Carter (2007) has suggested that for a racial encounter to be traumatic, it must be experienced as sudden, out of one's control, and highly negative.

Weathering is a phenomenon characterized by the long-term physical, mental, emotional, and psychological effects of racism and of living in a society characterized by white dominance and privilege.

Grit is defined as a perseverance and a passion for long-term goals, predicting a range of objective outcomes of success after accounting for individual differences in ability.

Significance of the Study

This study will add to the social work body of knowledge regarding the need to recognize raced-based trauma as a legitimate stress disorder among African-American males who have experienced racial discrimination and harassment. It will draw greater attention to the need for more culturally sensitive training among professionals as well as more culturally sensitive treatment interventions. Policy changes and the need for more research will also be discussed.

Stigma associated with mental health issues, such as traumatic stress, can serve as a significant barrier to mental health treatment and positive outcomes. According to the World Health Organization (2014), those with mental health conditions are among the most marginalized and vulnerable individuals in society. They are often isolated from their communities and may face restrictions in exercising their political and civil rights. In addition, they can have difficulty accessing health care, social services, and educational and employment opportunities.

Those living with mental health conditions have a greater likelihood of developing disabilities and premature death as compared to the general population. Efforts to address stigma and discrimination related to mental health issues are in progress in many parts of the world. Among the strategies used to address mental health stigma include social activism, public education, and contact with persons with mental illness. Further, public health leaders suggest that continued efforts to support services and policies that combat stigma and promote the well-being of those with mental illness must focus on creating a culture of social inclusion, with attention on the resiliency and strengths of this community. Policy makers, researchers, and clinicians are increasingly

aware of the intersecting effects of race, class, and gender on health (Krieger, Rowley, Avery, Phillips, & Herman, 1993). A growing number of studies document disparities in mental health treatment among minority racial or ethnic groups, such as African-American college students. More research is also needed to comprehend the broad physical health, mental health, and developmental impacts of childhood poly-victimization.

This chapter introduces the gap of research, research problem, purpose, as well as the research questions. These introductory segments will lead the study and define the significance of the study. Chapter II will provide further literature support for the topic and the research objectives.

CHAPTER II

REVIEW OF THE LITERATURE

The American Psychiatric Association (2000) describes posttraumatic stress disorder (PTSD) as an anxiety disorder characterized by a triad of symptoms following exposure to trauma, including persistent re-experiencing of the traumatic stressor(s) through flashbacks, nightmares, and/or intrusive thoughts; avoidance of stimuli associated with the trauma, along with the numbing of general responsiveness; and persistent symptoms of increased arousal. Mental health care providers do not typically consider racism to be traumatic.

Psychological difficulties attributed to racist incidents are often questioned or minimized, a response that only perpetuates the victim's anxieties. Thus, patients who seek out mental healthcare to address race-based trauma may be further traumatized by micro-aggressions, subtle racist slights, from their own clinicians when they encounter disbelief or avoidance of racially charged material (Williams & Leins, 2016). Many clinicians only recognize racism as trauma when an individual experiences a discrete racist event such as a violent hate crime. This is limiting given that many minorities experience cumulative experiences of racism as traumatic, with perhaps a minor event acting as "the last straw" in triggering trauma reactions (Carter, 2007).

PTSD was established as a diagnosis by the American Psychiatric Association (APA) in 1980. In 2000, the diagnostic criteria were revised for the fourth edition of its

Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR*). The fifth criterion addresses duration of symptoms, while a sixth criterion addresses functioning. PTSD and acute stress disorder (ASD) are similar in many ways but can be distinguished from one another by onset of symptoms. Symptoms of ASD occur immediately following a traumatic event, while PTSD symptoms typically manifest three months to three years after the traumatic event (American Psychiatric Association, 2000).

The social process of the trauma–PTSD relationship involves five variables: (a) cumulative adversity and trauma (CAT); (b) social strain; (c) agency (personal and interpersonal); (d) mental health service use (primary and specialized); and (e) PTSD symptom severity (Samuels-Dennis et al., 2010). Samuels-Dennis et al. stated that they introduced the intersectionality model of trauma and PTSD (IMT-PTSD) in a previous publication. This framework endeavors to account for observed discrepancies in mental well-being. The model integrates current empirical literature with principles of intersectionality and the process of stress formulation, and it outlines a social process through which PTSD develops and persists among women.

Samuels-Dennis et al. (2010) suggested that using the IMT-PTSD model, mental health is determined by macro-level factors (neighborhood structural and political characteristics) that intersect to shape power inequalities, discriminating social relations, and the distribution of health and social resources. As a result, according to Samuels-Dennis et al., these intersecting factors facilitate a meso-level trauma-PTSD process whereby gender-based trauma—non-naturally occurring traumatic experiences that are motivated and supported by entrenched beliefs about the socially ascribed roles,

responsibilities, and locations of individuals belonging to the male and female sexes—directly and indirectly impact women's and men's mental health and well-being through its influence on women's personal resources (agency), social resources (formal support/resources), and trauma-induced interpersonal stressors (social strain).

Section I: Race-Related Posttraumatic Stress Disorder

Racism in medicine, a problem with roots over 2,500 years old, is a historical dimension that continuously affects African-American health and the way in which this population receives healthcare. Racism is, at least in part, responsible for the fact African Americans, since arriving in North America as slaves, have had the worst health care, the worst health status, and the worst health outcome than most other ethnic groups. The atmosphere created by racial inferiority theories and stereotypes, 246 years of slavery, along with biased educational policies, almost inevitably led to medical and scientific abuse, unethical experimentation, and excessive utilization of African Americans as subjects for teaching and training purposes. Although very salient, African Americans have been underserved in a plethora of arenas, particularly in the field of education. Unfortunately, race-related trauma has been a significant part of the aspects of African-American culture that currently exist due to the trauma-riddled history of this nation.

It is imperative that researchers continue to explore factors that may lead to mental health problems among African Americans, as this issue is paramount to the future of African-American college students and their health concerns. Racial trauma is the physiological, psychological, and emotional damage that result from harassment and/or discrimination (Villatoro et al., 2017). According to Carter (2007), it is based in

the established evidence that demonstrates that racial discrimination and harassment in the context of racism are stressors for their targets. Racial discrimination is a form of *aversive* or *avoidant racism*, and racial harassment is a form of *domination* or *dominative racism* and is characterized by active hostility.

Critical race theorists recognize that racism and discrimination adversely affect the mental health of black students and faculty by diminishing their academic self-concept, confidence, and mental efficacy. Brought to the forefront by Smith (2016) and colleagues, this line of research introduces the concept of racial battle fatigue as a theoretical framework for examining the response to trauma and the experience of stress symptoms often manifested as anger, escapism, withdrawal, frustration, and avoidance (Smith, Mustaffa, Jones, Curry, & Allen, 2016). These stressors can occur at the macro level (society, institution, neighborhood) and on an interpersonal level (with an individual, in a classroom). The concept of racial battle fatigue maintains that race-related stressors, such as exposure to racism and discrimination on campuses and the time and energy African-American students expend to battle these stereotypes, can lead to detrimental psychological and physiological. Recent work in sociology and public health has sparked a growing interest in the distinct role racism plays in black people's mental health (Smith et al, 2016).

Public health researchers have concluded that racial and ethnic discrimination is a psychosocial stressor that can adversely affect mental health (Ryff, Keyes, & Hughes, 2003). Brown (2003) stated that the consequences of racial discrimination cannot be fully mitigated by well-established coping strategies, and that only the eradication of racism

will alleviate race-related stress for African Americans and other historically racialized populations.

Carter (2007) explains the ways in which racism can be a source of stress, trauma, and emotional injury. For counselors to effectively address race-based traumatic stress, they must first be educated and trained to recognize and acknowledge it. Race-based traumatic stress has been called by various names including but not limited to societal trauma, intergenerational trauma, racist incident-based trauma, insidious trauma, psychological trauma, and emotional abusiveness. Race-based traumatic stress can be defined as (a) an emotional injury that is motivated by hate or fear of a person or group of people as a result of their race, (b) a racially motivated stressor that overwhelms a person's capacity to cope, (c) a racially motivated interpersonal severe stressor that causes bodily harm or threatens one's life integrity, or (d) a severe interpersonal or institutional stressor motivated by racism that causes fear, helplessness, or horror. A study conducted by Copeland and Snyder (2011) revealed that key factors to consider when engaging low-income African-American women in mental health treatment services are thus: (a) fear of losing their children, (b) economic stressors, (c) role strain, (d) perceptions of the system, and (e) violence and survival. These factors negatively impact African-American women's decisions to seek help and should be considered in eliminating disparities in access to and utilization of mental health services.

Another factor to digest when engaging African-American college students, particularly males, is the discrimination shown by providers, which leads to the first potential source of disparity. Discrimination according to race/ethnicity is an intricate

behavior that can manifest from a number of sources, some malevolent, some not (Balsa & McGuire, 2003). According to Michalec and colleagues (2014)), a provider harboring a bias against a certain group may expend minimal effort on behalf of a member of that group, leading to discrimination. Discrimination can also derive from the negative stereotypes a provider might consider as true. For example, Michalec et al. stated that if a doctor has the perception that blacks are less likely than whites to comply with treatment, the doctor might prescribe differently based on race for otherwise similar patients. Many white Americans harbor negative stereotypes against black people. Van Ryn and Burke (2000) argued that "physicians may be especially vulnerable to the use of stereotypes in forming impressions of patients since time pressure, brief encounters, and the need to manage very complex tasks are common characteristics of their work."

In continuation of the arguments raised by Carter (2007), another article examined the need for: (a) counselor training on race-based trauma, (b) recognition of the parallels between PTSD and race-based trauma, (c) validation of a separate category for race-based trauma, (d) examination of racism as an additional trauma for survivors of other forms of trauma, (e) cultural competent assessment and intervention for race-based traumatic stress, (f) acknowledgement of the intersection between race-based trauma and other forms of societal traumas, and (g) the need to extend psychologists' lens to include international cases of race-based trauma.

Carter (2007) notes that all counselors, including counselors in training and those who entered the field prior to the implementation of cultural competence training requirements, need to receive education on race-based traumatic stress. This education

needs to include definitions of race, racism, and race-based traumatic stress as well as assessment needs, effects, and intervention strategies for race-based traumatic stress. There must be education on cultural traditions; the teaching of skills for culturally appropriate interventions; and the fostering of an understanding of power, privilege, and racial oppression. A grasp of these concepts is critical to a counselor's ability to recognize, acknowledge, and address race-based traumatic stress.

In addition to being at greater risk to exposure to traumatic stress, African-American college students report a plethora of exposure to racial discrimination. Pole, Gone, and Kulkarni (2008) note that chronic exposure to discriminatory experiences may make African Americans more vulnerable to psychopathology. In the case of PTSD, racial discrimination can result in greater exposure to traumatic stress in that those who experience discrimination may be placed in stressful situations intentionally.

The concept of statistical discrimination forms a tentative link between features of disparities in mental health care those in other types of health care. Michalec et al. (2014) asserted that the prevalence of mental disorders is generally lower among minorities, and a clinician's statistical thought process when encountering a patient from a minority group should therefore be that an ill patient is less likely to be ill than a white patient with otherwise similar symptoms. Consequently, a more serious indication of symptoms would be deemed essential to cause a clinician to revisit the prior enough to justify recommending treatment. In health, where minority groups may on average be worse off than white people are in receiving appropriate treatment, application of population priors will tend to favor rates of treatment for minorities.

Furthermore, in addition to a prior probability, the clinical decision-making literature refers to the "signal," or symptom report, coming from the patient. If communication is generally worse when the patient and doctor come from different ethnic, racial, or language groups, the doctor will give less weight to the resultant "noisier" signal (Balsa, McGuire, & Meredith, 2005). Minorities will be worse off on two counts, then, in connection with statistical discrimination; their lower priors and noisier signals lead to the lower probability that a patient with a given level of health care need will receive treatment. If statistical discrimination of this kind feeds into treatment decisions, disparities arising within the clinical concurrence are more important in mental health than in general health. In the case of mental disorders, where population pervasiveness is generally lower for minorities and where communication and understanding may be worse, this type of provider discrimination leads to lower rates of treatment for minorities.

Since racially discriminatory experiences are multidimensional in nature, CRT's multidimensional framework can help in identifying and highlighting the relationship between race and mental health. For example, the impact that racial stratification has on health outcomes could be further elucidated by using the select concepts and transdisciplinary methodologies provided by CRT (Ford & Airhihenbuwa, 2010). Some in the public health community have adopted the concepts of CRT to investigate structural racism in health care with the goal of using their findings to develop a health care praxis, one that expands community-based participatory research and thus results in the development of practices that benefit communities (Byrd & Clayton, 2012). The work

of these scholars has influenced our call to use CRT to address the mental and psychological stress and dysfunction that racism exacerbates in African-American college students when they experience heightened levels of racial stereotyping, discrimination, and other forms of bias.

Many critical race scholars acknowledge that African Americans and students from other historically marginalized groups often endure subtle but constant forms of discrimination and bias (Andrews & Tuitt, 2013). Counter-narratives of everyday experiences at traditionally white institutions regularly expose these institutions' denial that covert bias exists on their campuses. Marginalized students endure a plethora of racial assaults, which contribute to mental fatigue and psychological distress.

Carter (2007) noted some resistance to an association between racist incident-based trauma and PTSD for multiple reasons. One of the concerns is that a PTSD diagnosis will lead to victim blaming and pathologizing. It is important to note the following: (a) PTSD is one of only a few diagnoses that by definition is precipitated by an event (a traumatic experience), unlike other illnesses such as depression and anxiety; (b) no one who experiences a trauma should be pathologized, as post-racism distress is a normal response to an abnormal experience or a sane response to an insane stressor; and (c) calling a trauma by another word, such as injury, will not prevent those who seek to blame victims from blaming victims. As such, avoiding an association with the concept of PTSD does not truly address the problem. Research indicates that African-American college students underutilize mental health services, as compared to white students. Krishan et al. (2016) state that, according to the National Comorbidity Survey (NCS) and

the National Comorbidity Survey-Replication (NCS-R), among those with a mental disorder, African Americans are half as likely as white peoples are to receive psychiatric treatment when controlling for the severity of the disorder. African-American college students are also less likely than those of other racial/ethnic groups to receive treatment for a mental disorder through specialty mental health or general medical services. Also, Krishan et al. (2016) assert that African Americans have had more limited access to formal mental health services than to whites have.

St. John (2016) explained that while mental illness does not discriminate, our mental healthcare system does. Fewer than half of all adults in the United States who experience a mental health disorder receive treatment, but individuals belonging to various racial and ethnic minority groups receive treatment at an alarmingly lower rate than non-Hispanic whites do, though the rate of need for services may not be that dissimilar. St. John (2016) further asserts that critical barriers can be attributed to less access to treatment, whether the barrier is a lack of transportation, childcare, or the ability to take time off from work; an aversion towards seeking treatment due to attitudes about mental health; poor-quality care brought on by misdiagnosis and treatment from a provider who is not sensitive to the African-American college student experience; a high level of stigma that stems from cultural biases; a culturally homogeneous mental healthcare system with a dearth of minority providers who may better understand the plight of African-American men and women; racism, bias, or discrimination in the treatment setting, all of which exacerbate fear and mistrust in that setting; possible language barriers; and lower rates or lack of health insurance.

Though all of these barriers can cripple a minority group, there are policies and procedures that may help to improve the aforementioned conditions in order to create a better and more competent healthcare system and delivery of treatment. Some suggestions posed by St. John (2016) are to educate providers on potential barriers in order to bring about a deliberate awareness of experiences African Americans undergo; to train and hire providers that speak the language and from the same culture who can relate to some of the same experiences. It was also affirmed that developing outreach programs to help educate and bring a different perspective about mental illness helps to alleviate some of the misconceptions as well as increasing funding to mental health organization in the communities in order to eliminate logistical barriers and integrating mental health care and primary care through community partnerships.

Carter (2007) asserts that only education, prevention, intervention, and justice can work against the insidious and tenacious nature of racial oppression, victim blaming, and pathologizing. As scholars and researchers, psychologists can become distracted by debates over labels and linguistics while traumatic experiences of racism are themselves sorely neglected. It is important for counselors and researchers to find a necessary balance for all psychologists working in the trauma field; this balance is the cognitive space between understanding individual factors that moderate the relations between traumatic experiences and their effects while avoiding the pitfalls of victim blaming. While trauma and PTSD are not synonyms, researchers and counselors often merge the two, assuming that a person has only experienced a trauma if, as is noted in the diagnostic criteria for PTSD, he or she has experienced a physical violation (Carter, 2007)

Section II: Effects of PTSD on African Americans

Studies have shown that African-American college students report higher likelihood of trauma exposure and the development of PTSD when compared to other ethnic groups (Ai et al., 2011; McGruder-Johnson, Davidson, Gleaves, Stock, & Finch, 2000). The differential vulnerability model (Ulbrich, Warheit, & Zimmerman, 1989) suggests that African Americans, especially those from a lower socioeconomic class, are disadvantaged for two reasons. First, they are more likely to live in at-risk areas and thus will be exposed to greater numbers and more severe types of PTEs (differential exposure). Second, they are less likely to have access to financial and social resources; therefore, they are more vulnerable to the impact of negative life events regardless of the level of exposure (differential vulnerability). Although few studies have focused on trauma exposure and PTSD among African-American college students, the results of such studies have generally supported the differential vulnerability hypothesis, finding heightened risk of both trauma exposure and PTSD for African-American students (e.g., Ai et al., 2011; McGruder-Johnson et al., 2000). For example, African-American college students reported greater lifetime exposure to interpersonal violence and had higher rates of lifetime diagnosis of PTSD than European-American and Mexican-American college students did (McGruder-Johnson et al., 2000).

African-American college students also report greater perceived racial hostility, faculty racism, unequal treatment by faculty and staff, and pressure to conform to racial stereotypes than white and Latino students report (Juang et al, 2016), suggesting that trauma-exposed African-American students may face additional stressors and PTEs during college, and these factors in turn may place them at a higher risk for academic

difficulties due to increased distress. Although these risk factors—specifically, the high prevalence of trauma exposure and PTSD among African Americans—may be one of the contributing factors to the racial disparity in college graduation rates (Lynch & Engle, 2010), it appears that no study to date has focused on trauma exposure or PTSD symptomatology as potential predictors of college dropout among African=American students. In the present study, we focused on persistence into the second year of college of African-American students who reported lifetime exposure to PTEs.

Dissociation is "an interruption of a person's fundamental aspects of waking, consciousness, such as one's personal identity, one's personal history" (Maser, 2000, p. 1). Investigating the relationship between external factors and academic performance is important. According to Boyraz, Horne, Owens, & Armstrong (2013), "African-American college students reported greater lifetime exposure to interpersonal violence and had higher rates of lifetime diagnosis of PTSD than European American and Mexican American college students" (p. 583). The prevalence of trauma exposure rates within the African-American community is linked to limited economic stability and access to quality health care (Cecil & Matson, 2005; Feske, 2001). In comparison to white students, African-American students are more likely to come from communities with higher rates of violence (Ai et al., 2011; Charles, 2003). The aforementioned researchers examined self-esteem, social support, and religious coping as mediators between experiences of child maltreatment (CM), the inactivated polio vaccine (IPV), and symptoms of PTSD in a sample (N = 134) of low-income African-American women. Instruments used included the Index of Spouse Abuse, the Childhood Trauma

Questionnaire, the Taylor Self-Esteem Inventory, the Multidimensional Profile of Social Support, the Brief Religious Coping Activities Scale, and the Davidson Trauma Scale.

In the Wretched of the Earth, Fanon (1963) painstakingly provided an intimate examination of the colonized psyche, which often suffers from mental disorders, and the links between mental pathology and the French colonization of Algeria starting in 1830. Fanon has largely been characterized as a revolutionary anticolonial activist and intellectual, while his role as a psychiatrist has been downplayed. Fanon spent a significant portion of his later years practicing psychiatry in North Africa, where he closely and critically observed the psychic violence and affective dimensions of colonization. Although Fanon was trained in France, he criticized French psychiatry for using the field to justify the horrors of colonialism by detailing the racist assaults, both physical and psychological, inflicted on blacks in France and the United States. Additionally, he implicated these racist injuries in exacerbating and prolonging the suffering and anxiety of black people. His description of how Algerian people were stigmatized as slackers, liars, robbers, born criminals, and incapable of self-discipline is strikingly similar to the present-day racial stigma experienced by blacks in America.

Fanon (1963) detailed his own racial objectification by whites in ways that called his very humanity into question: “I subjected myself to an objective examination, I discovered my blackness, my ethnic characteristics; and I was battered down by tom-toms, cannibalism, intellectual deficiency, fetishism, racial defects, slave-ships, and above all else, above all: ‘Sho good eatin.’” (Fanon, 1967, p. 1). In a more recent article exploring the undertheorizing of race in research on the educational experiences and

outcomes of black people, researchers O'Connor, Lewis, and Mueller (2007) report that blackness is still given value and defined through objectified competencies and practices rather than through meaning making and the heterogeneity of the black experience. Fanon contends that people in positions of power have also suffered, but from an illness of moral consciousness. In addition, he discusses the anxiety experienced by the black middle class. Du Bois (1970) referred to this phenomenon as the psychological wage associated with being black—a sort of racial tax.

Edwards, Dardis, Sylaska, and Gidycz (2014) reported that both CM and IPV related positively to PTSD symptoms. Risk and resilience individual difference factors accounted for 18% of the variance in PTSD symptoms over and above IPV and CM, with self-esteem and negative religious coping making unique contributions. The researchers found that both variables mediated the abuse–PTSD symptom link. In addition, the researchers tested an alternate model in which PTSD symptoms mediated the relationship between abuse and both self-esteem and negative religious coping. One manifestation is when some black college students, while being socialized to work their way into the middle class by seeking white approval, concomitantly develop strategies to resist the internalization of inferiority. In research conducted over a hundred years ago, Du Bois (2007) set forth the premise that African Americans' history of slavery, oppression, and deprivation produced a collective memory and frame of reference that has significantly influenced the development of their culture. Du Bois also examined the identity confusion experienced by blacks in America, a sentiment that arose when racism, classism, sexism, and additional factors forced them to conform to a dominant American

identity, sometimes at the expense of their own ethnic identity. He highlighted the quandary some black people experienced when forced to sacrifice their ethnic identities in order to achieve academically and progress through the educational system.

This process has been shown to be maladaptive and can lead to stress, isolation, and anxiety due to the constant pressure to choose between conforming to the dominant culture or remaining true to one's own ethnicity (Navarette & Jenkins, 2011). African-American students who see a contradiction between their second-class status and their high academic achievement often suffer internal strife and may pay a high psychological price for their academic success. These students also may have difficulty with the third aspect of the Du Boisian "veil," where they struggle with the consequences of seeing and situating themselves outside of what the dominant group describes, defines, and prescribes for them (Du Bois, 2007).

Baker, Buchanan, and Spencer (2010) conducted a study that revealed a combination of health issues differentially affects the behavioral, psychological, and physical well-being of African-American women. The researchers maintain that these disparities are both the result of and contributors to marked differences in the perception, interpretation, and treatment of various psychological disorders and chronic medical conditions. PTSD affects 8,000,000 adults each year and about 4% of men throughout their lifetimes, according to the U.S. Department of Veterans Affairs (2002). Mothers are not the only adults who are severely affected by PTSD; while it is unclear how many fathers struggle with PTSD, about half of all American men are fathers (source), and it can be conjectured that roughly four million fathers may be dealing with violent

flashbacks, intrusive memories, debilitating panic attacks, and other PTSD symptoms. Since a growing body of evidence suggests that fathers are disproportionately affected by PTSD, four million might actually be an underestimate. Without significant interventions, these fathers will pass down their suffering to millions and millions of children. There is some evidence of that PTSD can be contagious, and that the untreated mental health issues of afflicted fathers can have negative impacts on these men's children.

African Americans experience significantly more instances of discrimination than either Asian or Hispanic Americans (Chao, Asnaani, & Hofmann, 2012). Non-Hispanic whites experience the least discrimination (11% for whites versus 81% for blacks; Cokley, Hall-Clark, & Hicks, 2011). Furthermore, those African Americans who experienced the most racism were significantly more likely to experience symptoms of PTSD as well. Findings from large-scale national studies indicate that, while African Americans have a lower risk for many anxiety disorders, they have a 9.1% prevalence rate for PTSD, compared to 6.8% in whites (Himle et al., 2009).

Many mental health studies in the early twentieth century concluded that blacks had higher rates of mental illness than whites, reporting that the black participants were considered severely mentally ill while the white participants were described as exhibiting varying degrees of mental illness (Roberts, 2011). These biased conclusions have been discredited by large-scale studies such as the National Institute of Mental Health's National Comorbidity Study, the largest study of mental illness ever conducted in the United States. Though none of this research has presented a holistic picture of African-American mental health (Kessler, 1994) these studies nevertheless address the fact that,

although African Americans are disproportionately exposed to known risk factors for physical and mental illness, they do not have higher rates of suicide or mental illness than white people have. Still, it should be noted that among high-achieving black people with high socioeconomic status, the stress and anxiety associated with racism routinely results in a high level of stress-related illnesses (Bennett et al., 2004).

Differences in sample composition could contribute to discrepant findings. For instance, Kubany et al. (2004) compared Caucasians with a coalition of multiple non-Caucasian ethnic and racial groups instead of conducting comparisons between individual racial groups, a design that could have produced different findings. Aside from the factors suggested earlier, this study also explored other variables that would explain the higher treatment terminations found in African-American participants above and beyond race.

One major factor in comprehending PTSD in African Americans is the impact of racism on emotional and psychological well-being. Racism continues to be an integral part of American society, and racial barriers have an inordinate effect on the oppressed. Though a profusion of research has been conducted on the social, economic, and political effects of racism, not much has been collected on the psychological effects of racism on people of color (Carter, 2007). Race still accounted for an elevated risk of premature termination from the protocol in the analyses even after controlling for the effects of income and education. Racial differences in early treatment termination also remained after accounting for trauma history and treatment expectations. Because this is a relatively unexplored topic, there is no research to support or refute the findings on the

complex relationships among race, dropout, and many other variables examined in this study. Previous studies on PTSD have not sufficiently accounted for the effects of income, education, or other relevant variables in their analyses (Lester et al., 2010).

Section III: Access to Treatment/Healthcare Disparities

According to Byrd and Clayton (2001), race and racism are major factors in the United States health system and help define one of America's health dilemmas: through its creed equity for all men but showed differently in its practices. The authors further state that effects throughout the health system are seldom acknowledged and often downplayed. Race is important in the American healthcare system, whether viewed from the perspective of racism in turn affecting clinical decision-making regarding patients; white indifference to the African-American Health issues and feelings; copious amounts of discriminatory barriers to African American entry into the prestigious health professions; and unfair and biased treatment after African Americans become physicians, dentists, nurses, etc. (Shulman et al., 1999; Clayton et al., 1999).

During the early decades of the 20th century, the healthcare system had come increasingly under the control of predominantly white medical schools (Rosenberg, 1987). Hospital and health facilities continued to be rarities for the majority of black population in the south. Meharry Medical College and Howard University School of Medicine functioned as virtually the sole sources of trained black medical and health care professionals between 1910 and 1970. Morias (1967) stated that black representation in the medical profession rose to a mere 2% around 1900 and remained at that level into the 1980s. Few realized this underrepresentation would generate future medical educational

problems threatening black representation within the medical profession and the very survival of black medical schools.

Black patients continued their traditional roles as over-utilized subjects for medical demonstration, dissection, risky surgeries, and experiments, furthering a trend that had begun during slavery amid the rise of clinical training, anatomic dissection, and clinical research in medicine (Savitt, 1982). The Tuskegee Syphilis Experiment, for example, was an unethical, exploitative experiment in which treatment for syphilis was withheld from some 500 rural, illiterate, poverty-stricken black men. The study commenced in the early 1930s, lasting for more than 40 years, and because the Tuskegee medical researchers deceptively told the male subjects they were being treated, these subjects remained in the experiment despite the excessively high morbidity and mortality rate (Jones, 1996). The President of the United States formally apologized to the living Tuskegee survivors and the entire African-American population in 1998. Discovering these types of unethical experiments disaffected and appalled African Americans, particularly men, and contributed to their mistrust of and anxiety toward the medical community, discouraging them from seeking treatment for physical or mental ailments.

According to Byrd (1986), the mainstream medical profession continued a pattern of discrimination toward African Americans and poor Americans as patients or peers and continued to support patterns of institutional racism, class bias, and professional racial discrimination in the health system into the 1990s. Disparate health status and outcome data have reflected these culturally destructive policies, practices, and health system environment. Moreover, as we enter the new millennium, the majority of African

Americans remains demographically, economically, and socially segregated and isolated within our nation's depressed inner cities (Wilson, 1987). These areas continue their history of being medically underserved and subjected to substandard health care by the underfinanced, inferior, public tier of the nation's inequitable health care system (Jones & Rice, 1987). Black medical professionals are the only consistent spokespeople for black people and the poor in the health care system, but black representation in this field is threatened by cuts in medical educational financing, failure to support black medical schools, and a shift away from minority health priorities and affirmative action policies in white medical schools (Hanft et al., 1983). Dowling (1982) explains that the growing black lower class will continue to be served by the inferior public health subsystem and ignored by private sector medicine. The public institutional infrastructure, though serving a laudable purpose, has not adequately met the medical needs of black and poor populations for more than three centuries, understandably resulting in subpar health outcomes. Without major reforms, the healthcare system will continue to play its seemingly predetermined deficit-producing role in providing inadequate healthcare services to the African-American community.

In a review of the literature, Cusack et al. (2007) was noted that a virtual lack of empirical investigation of trauma exists within the psychiatric setting, not to mention the cultural or racial minority issues that often go unaddressed. These researchers argued that many African Americans were not aware of the symptoms of PTSD, a trend that would in turn cause many veterans to self-medicate as well as choose other ways to deal with the ongoing perplexities of their lives. Furthermore, the authors recommended a

much more sensitive and precise cultural approach for African Americans in light of this knowledge.

A study conducted by Seng, Kohn-Wood, and Odera (2005) that explored factors contributing to disparities in PTSD diagnoses between African Americans and white Americans, controlling for gender and class and using a data set limited to poor women. The sample consisted of a total of 20,298 African-American and white-American adolescents and adult women, including 2,996 with PTSD diagnoses. The research's results revealed that African-American women were underrepresented in the group diagnosed with PTSD (12% versus 31% in the comparison group) despite having equal rates of hospitalization for rape and battering (Seng et al., 2005). Results also showed that African-American women were less likely to be diagnosed with comorbidities associated with complex PTSD, such as dissociative disorder ($OR = 0.259$, $p < .001$) or borderline personality disorder ($OR = 0.178$, $p < .001$), but were equally likely to be diagnosed with conduct disorder, schizophrenia, or substance abuse. One of the main findings was that African-American women were 40% less likely to have continuous insurance coverage.

According to Williams and Mohammed (2009), racial disparities in health in the United States are large and pervasive. For most of the 15 leading causes of death, African Americans have higher death rates than white people do. The authors further report other data indicating that 100,000 black persons who die prematurely each year would not die if there were no racial disparities in health. In spite of the fact that life expectancy has increased for blacks and whites, there remains a racial gap in life expectancy.

Socioeconomic status and environmental factors must be considered as causal factors for PTSD in African Americans. Public and private stigma influences as well as distrust of the mental health care system hinders members of ethnic minorities from receiving adequate mental health care. This gives an opportunity for mental health issues such as PTSD to manifest at a higher mortality and morbidity rate (Beristianos, 2014). Based upon the relentless and powerful nature of stigma, an impactful approach to its eradication of the stigma against mental health issues is a major public health policy objective in service to a more global outcome or goal in reducing mental health disparities that currently exist among the African-American community. Culturally relevant research studies are needed from the perspective of self-stigma, self-esteem, self-worth, and self-depreciating attitudes and behaviors (Beristianos, 2014). According to Gary (2005), health policy makers should also support interdisciplinary learning among all health professionals with an emphasis on research and health policy. As research continues to develop and expand, it is essential that all disciplines recognize the complexities that are inherent in human behaviors as well as mental disorders among all populations.

Participants in a study conducted by Gutner et al. (2016) were victims of interpersonal violence drawn from two large treatment outcome studies of cognitive-behavioral treatment for PTSD conducted consecutively. Because the original studies were not designed for the study of race and its impact on treatment, there was no access to detailed measures of race and ethnicity. The self-identified racial composition for the combined study (n=321) was 67% Caucasian, 29% African-American, and 4% of other

racial backgrounds. Only Caucasian and African-American participants were included in group comparisons because of the low representation of other racial groups, resulting in a total sample of 308.

The first of the two studies consisted of 171 participants randomized into cognitive processing therapy, prolonged exposure, or a wait-list condition (Gutner et al, 2016). Participants in the wait-list condition were randomized into cognitive processing therapy or prolonged exposure after a six-week waiting period, and their data were included in analyses presented in this article. In the second study, the full cognitive processing therapy protocol was compared with its constituent components: cognitive therapy and written accounts.

The second study consisted of 150 participants who were randomized into one of the three conditions (Gutner et al, 2016). The authors of the subsequent study report that participants were women who met criteria for PTSD at the time of the initial assessment; were at least three months post-trauma (no upper limit); and, if on medication, were stabilized as determined by a psychiatric consultation. The duration for medication stabilization depended on the medication and whether it was a new medication or a change in dosage. Generally, the duration for medication stabilization was two months for a new selective serotonin reuptake inhibitor.

Participants with current substance dependence were included in both studies if/when they had been abstinent for six months. Those with substance abuse were permitted to participate if they agreed to desist in usage during the period of treatment. In fact, there were only four participants who met criteria for current alcohol abuse in the

sample, all of whom were Caucasian and none who demonstrated other types of substance abuse. Lifetime substance abuse history was not collected in the second study. In the first study, there was not a significant race difference in lifetime alcohol abuse or dependence, although 38.3% of Caucasian participants reported abuse or dependence at some point compared with 7.8% of the African-American sample (Lester et al., 2010). The length of active treatment (approximately six weeks) and total hours of therapy time (12–13 hrs.) were also similar across studies. Differences in the study designs emerged in the treatment conditions (with the exception of the cognitive processing therapy treatment condition) and the handling of early terminators (Lester et al., 2010).

This study was lacking balance as it relates to the researchers: the more active involvement by African-American researchers, the more valid the research. Analyses were conducted to test for racial differences in the three treatment completion status groups while adjusting for potential covariates (age, education, income, treatment expectations, and trauma history). Multinomial logistic regression with maximum-likelihood estimation was used to examine the relative risks of dropout and never starting therapy associated with African-American participants as compared to Caucasian participants (Gutner et al, 2016).

African-American men have been isolated from the mental health system primarily due to attitudes, beliefs, and stigmas about owning their mental health issues as well as mistrusting the providers if they decide to seek care. This is an unfortunate but common occurrence in the minority community that has to seek refuge through policies and procedures in order to improve their lives and the processes of the healthcare

systems. African-American men who are not veterans constitute a population that is less likely to seek treatment or receive a correct diagnosis of PTSD.

The issues surrounding PTSD and diagnosis are compounded by health disparities in African-American communities. Many African-American men are reluctant to go to the doctor because of misdiagnosis or mistreatment. There is also the perceived weakness surrounding asking for help for men. Armstead says many men may not see PTSD as something for which one should even go to the doctor (Danois, 2015).

According to Primm (2016) who has worked in the area of health disparities as it relates to African Americans for decades, co-founding a treatment program that provided in-home mental health treatment to patients, PTSD diagnoses are more common in women than in men, and that disparity holds true in African-American communities. Black men are less likely to receive a diagnosis of PTSD. The idea that seeking help is seen as a weakness, Primm said, is directly related to stereotypes that people hold of individuals with mental illness, namely, that mental illness is laziness or a character flaw rather than a disease. He stated that the socialization of black men has made some of them think that people with mental health problems should snap out of it and literally pull themselves up by their bootstraps. In military cultures, this attitude seems to be particularly pronounced.

Multiple sociocultural factors related to attitudes, beliefs, and value systems may interact to shape African Americans' experiences in therapy. A few existing theories offer reasons for African Americans opting out of any type of mental health treatment at a higher rate than Caucasians or members of other racial groups do. According to Daniel

(2000), some of the theories that exist are informative in terms of providing historical and sociocultural contexts for race and racial differences but can be seen as fairly broad, and many have not adequately been tested in controlled research conditions.

Based on previous research, one area where racial differences may exist is that of psychotic and dissociative symptoms (Frueh, Smith, & Libet, 1996). According to Frueh et al. (2002), the evidence suggested that positive symptoms of psychosis may occur in 30–40% of males and may represent a distinct subtype of disorder with unique biological features. This was an indication that a biological component to psychotic symptoms in this population. It has been well documented in other anxiety disorder populations that African Americans describe their symptoms differently than Caucasians do, and this often results in incorrectly diagnosed psychotic features or disorders (Frueh et al., 2002). Ostensibly, the differences in presentation of psychotic symptoms between racial groups may be related to the manner in which patients describe their symptoms rather than to actual phenomenological differences.

There is evidence that African Americans may be more likely not to utilize mental health services in both Veterans Affairs (VA) and other healthcare sectors (Frueh et al., 2002). Additionally, there is data to suggest that African Americans may be more likely to receive neuroleptic medications than their Caucasian counterparts are. These findings are consistent with research from general populations showing that African Americans are more likely to be misdiagnosed/underdiagnosed and are less likely to receive treatment (Frueh et al., 2002).

Racial segregation, both legal and *de facto,* has effectively limited the level and nature of contact between African-American and European-American people so that many European-American professionals are not familiar with the life context of their African-American clients (Daniel, 2000). It has also been documented that help-seeking behaviors of African Americans may reflect characteristic coping styles, and the stigma about receiving psychological care has implied that many African Americans perceive therapy as contributing to the process of being labeled as "crazy." There is thus a common anxiety over the reactions of extended family and friends and being separated from their community (Boyd-Franklin, 2003).

Postsecondary institutions throughout the United States are facing increasing pressure to meet the needs of students struggling to overcome environmental stressors including trauma. According to a report by the American College Health Association (2013), more than 30% of students reported feeling depressed. Ensuring students have access to comprehensive mental health support can help students cope with traumas including intimate partner violence and sexual assault. Even if the mental health services are available, a person without a PTSD diagnosis does not know to seek professional help.

Finally, the theme of the therapist as prying too deep into the lives of African-American clients has been discussed as a major factor contributing to the reluctance of African Americans entering treatment and prematurely discontinuing therapy. These factors may have contributed to ambivalence and to the higher rate of African-American participants never starting treatment after enrollment in the study or dropping out before

completing the protocol. If comfort and trust have not been established in the therapy setting, it can be potentially difficult for many African-American clients to open up and begin telling their life stories to someone who is perceived as an outsider of their community (Boyd-Franklin, 2003).

A practical approach to addressing some of these issues might be for clinicians to spend time prior to or early in treatment building rapport and discussing cultural differences. Setting expectations, taking time to socialize patients to the therapy process, and clearly explaining the rationale for therapy assignments that may be culturally or personally unfamiliar are all tactics that have the potential to make a difference (Lester et al., 2010).

However, investigations have documented the extent of ethnic/racial diversity or described variations in early posttraumatic distress for injured minority patients treated in acute care inpatient settings. A recent national study examined PTSD symptom development 12 months after injury in 2,931 patients recruited from 69 American acute care hospitals (MacKenzie et al., 2006; Zatzick et al., 2007). The investigation identified a significantly elevated risk of 12-month post-injury PTSD symptoms among American Indian, African-American, and Hispanic injury survivors relative to non-Latino white injury survivors; significant group differences persisted even after adjustments for relevant clinical and demographic characteristics (Zatzick et al., 2007).

Another previous investigation suggested that minority patients treated in acute care medical settings may be at risk for receiving poor quality medical care; in a single-site emergency department study, Latino patients with long bone injuries were twice as

likely to receive no pain medication when compared to non-Latino white patients (Todd, Samaroo, & Hoffman, 1993).

Additionally, it was not possible to examine the impact of therapist-patient racial matching because there was an insufficient number of African-American therapists (four of the 16 therapists). The role of sociocultural and individual factors, such as coping style and treatment preference, should be explored as potential moderators of treatment. These types of analyses are important in understanding who is likely to benefit from a given type of treatment and why. Future studies specifically designed to examine the role of race and ethnicity in treatment outcomes should include a more culturally sensitive examination of ethnicity, including the use of measures of racial identity, acculturation, and perceived discrimination. This will help uncover potential intra-ethnic group differences, enabling more sophisticated analyses to be conducted (Pole et al., 2008).

According to Stockman, Hayashi, and Campbell (2014), African Americans undergo more severe incidents than their Caucasian American counterparts but do not have the resources to cope with them. The researchers assert that greater loss of social and/or material resources contributes to greater distress. In addition, attention may be drawn to the importance of distinguishing severity from frequency of trauma exposure in understanding PTSD rates and symptom severity.

Within mental health treatment settings, African Americans have been found to receive less comprehensive mental health care and are provided with fewer follow-up services. African Americans are treated by providers who have less training and fewer resources available to them, and they are more likely to report being treated with

disrespect by providers. Also, African Americans come in contact with the mental health system later in the course of the illness for different reasons than Caucasians do. All of this data suggests that the experiences of traumatic and harmful events that can be treated in a psychiatric setting may be qualitatively different for African Americans compared to Caucasians (Cusack et al., 2007).

There is something to be said for African Americans, particularly college students within that population, receiving subpar psychiatric treatment. Much more emphasis must be placed on studying this pervasive trend. Additional reasons to hypothesize racial disparities in experiences of trauma and harm in the psychiatric setting come from studies examining specific hospital practices. These studies have found that African Americans are more likely to be involuntarily committed, put in selection or restraint, and treated with high doses of antipsychotic medications than Caucasians are (Cusack et al., 2007). It is imperative that we treat this issue with the utmost respect and concern due to the magnitude of its potential negative fallout.

African-American college students have relied on a gamut of resources to address mental health problems, but they refrain from bringing sensitive matters like mental health issues to a system that has historically been less than sensitive to the institutional and systemic challenges African Americans typically endure. The most common barriers are the significance of family privacy; deficit of awareness regarding available treatments; denial of mental health problems; and concerns about stigma, medications, and treatment (Ayalon & Alvidrez, 2007).

According to Davis and Ford (2004), sociocultural barriers include racial and ethnic discrimination, cultural beliefs such as fear and mistrust of the mental health care system, and community views regarding mental health and mental illness. Stigmas are one of the most typical barriers to seeking treatment. Systemic barriers include those that result from inherent aspects of the mental health care delivery system, such as perceptions of mental health service providers toward African-American college students and culturally inappropriate screening measures, diagnostic procedures, and treatment programs. Economic barriers are obstacles to mental health services resulting from economic status, such as lack of health insurance or mental health coverage. Finally, individual barriers comprise perceptions of vulnerability to disease and denial of disease (Swanson & Ward, 1995). All of these barriers may have a significant impact on mental health services utilization and the quality of mental health care received by African Americans college students.

According to the World Health Organization (2010), those with mental health conditions constitute one of the most peripheral and susceptible groups in society. They are often shut off from their communities and may face limitations in exercising their political and civil rights. In addition, they can have challenges accessing health care, social services, and educational and employment opportunities. Efforts to address stigma and discrimination related to mental health issues are in progress in many parts of the world. Among strategies used to confront mental health stigma include social activism, public education, and contact with persons with mental illness (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012). Additionally, public health leaders suggest that

continued efforts to support services and policies that combat stigma and promote the well-being of those with mental illness must focus on creating a culture of social inclusion, with emphasis on the pliancy and potency of the community (Carter, Satcher, & Coelho, 2013).

Many African-American college students are suffering from abusive behavior relative to treatment and diagnosis for PTSD in more ways than one. As Carter (2007) significantly observes, it is important to recognize the multiplicative effect race-based traumatic stress can have on survivors of other forms of trauma. Examples of this multiplicative effect include the traumatic race-based and class neglect experienced by Hurricane Katrina victims as well as race-based trauma experienced by ethnic minority rape victims in their encounters with the judicial system. It is therefore imperative for counselors to be cognizant of the potential for the additional race-based traumas facing racially marginalized survivors of other severe stressors such as war, domestic violence, and assault. Given the vulnerability and violation already affecting these survivors, it is particularly vital for trauma counselors such as those working with rape crisis centers, veterans' hospitals, domestic violence shelters, and emergency response workers to be trained in race-based trauma assessment and intervention. In other words, counselors and researchers must consider the impact of being raped physically and then being emotionally "raped" by systems and institutions that devalue, minimize, or ignore members of one's race. These race-based violations can add and in some cases multiply the traumatic stress of survivors (Bryant-David & Ocampo., 2005).

Section IV: African-American College Students

Although very salient, African Americans have been underserved in a plethora of arenas, particularly in the field of education. Unfortunately, race-related trauma has been a significant part of the African-American culture that currently exists due to the trauma-riddled history of this nation.

Since their inception, historically black colleges and universities (HBCUs) provided a nurturing environment for African-American students in spite of economic, educational, political, and social disparities. According to Allen and Jewell (2002), "HBCUs embody the African-American quest for education. In the face of numerous obstacles, HBCUs have functioned as multifaceted institutions, providing not only education but also social, political, and religious leadership for the African-American community" (p. 242). In 1862, President Abraham Lincoln signed the Morrill Land Grant Act, which ushered in a new era of federal spending (Harper, Patton, & Wooden, 2009). The federal government allocated land, which allowed states to establish post-secondary institutions with an emphasis on agricultural and military science. Eventually, the money from the initial Morrill Act would fund the nation's first historically black land grant institution, Alcorn State University (Brown & Davis, 2001).

The majority of the funding from the Morrill Act did not provide training to the millions of slaves freed after the Civil War (Allen & Jewell, 2002; Harper et al., 2009). After the Civil War, African Americans endured *de jure* segregation, which limited opportunities to vote, own land or develop basic literacy skills (Du Bois, 1903; Du Bois, 1994). In 1890, the federal government enacted the second Morrill Act, which led to a spike in the number of HBCUs (Christy & Williamson, 1992). The funding created a

series of institutions dedicated to educating African Americans. Unfortunately, more than one hundred years later, students at HBCUs are more likely to attend post-secondary institutions with dilapidated facilities and limited resources in comparison to students from predominantly white institutions (PWIs; Palmer, Davis, & Gasman, 2011).

Moreover, because of ecosystemic factors, including familial relationships, government policies, community, and school violence, African-American students are more likely to be exposed to traumatic events, which hamper their ability to complete their post-secondary education (Boyraz, Horne, Owens, & Armstrong, 2013; Brown, Cohen, Johnson, & Smailes, 1999; Nikulina, Spatz-Widom, & Czaja, 2011). African-American college students from urban communities encounter a myriad of problems prior to matriculating at post-secondary institutions including living in communities with limited economic, political, and social capital (Robinson, 2000). Noguera (2003) asserted urban public schools frequently serve as important social welfare institutions. With meager resources, they attempt to address at least some of the nutritional and health needs of poor children. They do so because those charged with educating poor children generally recognize that it is impossible to serve their academic needs without simultaneously addressing their basic need for health and safety.

Section V: Academic Achievement

Larry J. Walker is a research fellow in the School of Graduate Studies at Morgan State University and is considered a highly qualified expert on PTSD. His research examined the impact environmental factors have on the academic performance and social-emotional functioning of students from HBCUs. Walker's work is published in the

Diverse Issues in Higher Education Journal and by the University of Pennsylvania's Center for Minority Serving Institutions (CMSI) (2005). Walker, a former congressional fellow with the Congressional black Caucus Foundation (CBCF) and legislative director for former Congressman Major Owens of New York's 11th Congressional district, has several years of experience examining policy issues. During his tenure on Capitol Hill, he worked on amendments to the Higher Education Act (HEA), fought for increased funding for HBCUs, and worked closely with stakeholders. Walker earned his Ed.D. from Morgan State University, which prepared him to study curricula geared towards solving problems in the educational system.

The significance of Walker's study hinges on his sample (HBCUs), which narrows the data's prevalence concerning PTSD and African-American college students. Identifying policies and programs that increase academic performance, retention, and graduation rates are vital to the future of HBCUs and their students. Walker's (2005) research examined the experiences of 227 African-American undergraduate students at a public HBCU located in the Mid-Atlantic. The utilization of undergraduate students allows an ongoing sample of data to determine the comparison between intervention and non-intervention groups of PTSD symptoms identified among the 227 students.

The study focused on three research questions: (a) What are the number of exposures to trauma, the frequency of exposure to traumatic events, and the age of exposure to trauma as measured by the Trauma History Questionnaire (THQ) for African-American undergraduate students attending a public HBCU? (b) Is there a statistically significant relationship among the number of exposures to trauma, the

frequency of exposure to traumatic events, and grade point average for African-American students attending a public HBCU? (c) Is there a statistically significant predictive relationship among the number of exposures to trauma, the frequency of exposure to traumatic events, and grade point average for African-American students attending a public HBCU?

Walker (2015) revealed that the findings have implications for HBCUs throughout the United States. Addressing the emotional and social needs of students is vital to increasing student completion rates at HBCUs. African Americans are more likely than white students are to have exposure to primary or vicarious trauma. Identifying and developing treatment protocols for susceptible populations could increase student academic performance and self-efficacy at HBCUs. A study conducted by Seng et al. (2005) explored factors contributing to disparities in PTSD diagnosis between African Americans and white Americans while controlling for gender and class by using a data set limited to poor women. The sample consisted of a total of 20,298 African-American and white-American adolescents and adult women, including 2,996 subjects with a PTSD diagnosis.

Afrocentric Perspective

The Afrocentric perspective is one that reflects the thoughts and worldviews from the perspective of those of African descent. This perspective is designed to eradicate the Eurocentric thoughts that have been thrust upon African Americans, Africans, and people of other colors who have been oppressed, disenfranchised, and downtrodden. The Afrocentric perspective offers another way of viewing the world other than that of

Eurocentric hegemony, which has influenced the world for the last five hundred years. This perspective is sorely needed and long overdue because of how Eurocentrism has torn at every fiber of the history and culture of Africans and other oppressed people, especially African-American college students. Asante (1987) asserted that for the Afrocentrist, one of the key assumptions is that all relationships are based on centers and margins and the distances from either the center or the margin. When black people see themselves as central in their own history, they see themselves as agents, actors, and participants rather than as marginal on the periphery of political or economic experience.

Asante observed that African people have developed their own perspective of history and culture, distinct from the perspectives of other people. There have been enough people with the knowledge and money to establish think tanks pertaining to this issue. The notion that the Afrocentric perspective as a fundamental necessity for anyone declaring competency in almost any subject in America is well informed. Otherwise the person would basically remain ignorant to a major portion of the world.

One of the consistent and disturbing features of my undergraduate and graduate training was the pervasiveness of academic theories that emerged from black mentors who were not of my ethnic group. Regardless of the course, the textbook and the theories discussed were almost exclusively by Eurocentric authors. Initially, much attention was not paid to this fact. However, as time went on and as I became exposed to new material that underscored and illuminated my oppression as a black man in white America, I became more conscious of the hegemony white people had over the knowledge validation and information dissemination process in academia (Schiele, 1997).

Woodson's work (1936) is one of the most important in the emergence of the Afrocentric perspective as an intellectual and life framework. Through the eyes of Woodson, an early history pioneer with a Ph.D. from Harvard, the Afrocentric perspective offers a social, economic, and practical framework that positions Africa and African Diaspora issues at the core of its vision and work, and it seeks to reclaim and uncover the expressed contributions of African people while working for continued improvement of Africa, the world, and people both of African and non-African descent. Woodson was well-known for a classic piece of work, the *Mis-education of the Negro* and he also penned *The African Background Outlined* or *Handbook for the Study of the Negro*. Woodson (1936) masterfully lays out the social context of pre-colonial Africa, its contributions and major civilizations, and its connation to the black-American experience at a time when academic racism and dehumanization of African culture and people were the standard for anything concerning Africa. Woodson, obviously under internal duress, provided evidence in a general outline of history that placed Africa at the center of the human experience.

This great work provided a background and delineation of African culture and Africans' survival in America as well as their influence in education, literature, arts, and economics. There was much respect for Woodson by his peers; Du Bois remembered Woodson with great reverence, saying that Woodson adhered to one great goal, worked at it stubbornly and with unwavering application, and died knowing that he accomplished much if not all that he planned (Wiggan, 2010). After his death, Du Bois and other scholars recognized Woodson as the Father of Black History. His imprint on the

Afrocentric perspective should never be minimized or taken for granted, as his push for the principles and values of this perspective to become as prevalent as the Eurocentric hegemony are as pertinent as the work of any prominent scholar of any era.

While describing prominent authors who actually lived out the principles and values of the Afrocentric perspective, there is one name that stands out among the rest: W.E.B. Du Bois, dubbed the Father of Militant Journalism. Du Bois was a professor at the highly esteemed Atlanta University and received a Ph.D. from Harvard. He had the respect of peers such as Woodson and Ida B. Wells, as he embarked on a mission to head the Negro protest for civil liberties. Du Bois, while on his way to becoming the most prominent civil rights leader and protester of his time, co-founded the National Association for the Advancement of Colored People (NAACP) and was also the editor of an important publication called *The Crisis*, from which volumes of writings were published that helped to chart a path to social justice for African Americans.

The reason Du Bois was nicknamed the Father of Militant Journalism was because of his penchant for journalistic writing aimed at social, economic, and political transformation, and the transformation is characterized by scholarship that questions and challenges oppressive institutions. While providing a voice for the oppressed, the transformation also presents direction and acts as a blueprint for the progress of the masses. In essence, this type of journalism helps to shape and change public opinion by appealing to the conscience of a nation to address systemic injustices and group domination. Due to the critical conditions of African Americans and the severe treatment that they endured, which included lynching public beatings, Jim Crow segregation, mass

unemployment, and a lack of human rights, Du Bois was compelled to write in a critical, commanding, and elegant tone. As a journalist and scholar, Du Bois argued that all forms of scholarship should be used for social justice work and to improve the plight of people of African descent (Rojas & Liou, 2014).

Du Bois used his platform as editor of *The Crisis* to have a profound impact on both blacks and whites during his tenure, particularly between 1910 and 1917. He also corresponded with the height of his influence on America and race relations. During this time, Du Bois put his stamp on the Afrocentric perspective as he spoke out against American racial injustices. Du Bois forced the nation to reckon with its past and present crusade against people of African descent. He made it his personal and civic duty to speak out against all social injustices, writing monthly about the social ills in the United States and around the world.

Much of his pioneering work in advancing the Afrocentric perspective was done at Atlanta University after suffering at the hands of scorn through racism; Du Bois was not exempt from the social ills from which he tried to protect the world. I would be remiss if I did not mention one of his most famous works, "The Souls of Black Folk" (1903), in which Du Bois discusses the ugly veil that separates African Americans and whites as well as the "two-ness" that most blacks face in the United States; this "double consciousness" forces black people to constantly see themselves through the eyes of the Other (white people) and are compelled to measure themselves against that Other. Du Bois argued that this two-ness creates a great level of stress and discomfort in the lives of

African Americans because the racialized perceptions of the Other remain a permanent feature in their psychology (Wiggan, 2010).

The Afrocentric perspective contextualizes the experiences and behaviors of an oppressed people, placing African value systems, culture, and experiences at the center of study and consideration. Although the Afrocentric perspective does not seek to exclude other viewpoints or worldviews and thereby claim its assumptions and value systems to be universally applicable, it does assert the primacy of the African experience for African people (Mazama, 2001). In addition, the Afrocentric perspective views the European voice as just one among many and not necessarily the wisest one. This way of thinking predates the influence of Arab and European colonizers and has maintained much of its integrity despite those influences (Mazrui, 1986; Schiele, 1996). Among the major tenets of the Afrocentric perspective are the belief that all things are connected and a deeply rooted sense of spirituality (Asante, 1988; Schiele, 1996; Schiele, 1997). According to Schiele (1996), the Afrocentric perspective is built on three major assumptions:

1. Human identity is a collective identity. This model acknowledges that an individual cannot be understood outside his or her social context. The concept of a collective identity encourages an emphasis on sharing, cooperation, and social responsibility.
2. The spiritual or nonmaterial aspects of human life are as important as the material components are. Spirituality from an Afrocentric perspective can be defined as that invisible, universal substance that connects all human beings to each other and to a Creator or a Supreme Being. Spirituality from an

Afrocentric perspective is not vested in any one religious tradition, nor does it imply that one is powerless in the face of other forces. Instead, Afrocentric spirituality hinges on the belief that spirit is invested in everything.

3. The effective approach to knowledge is as valid as other forms of knowledge. From this perspective, all aspects of the individual, mind, body, and soul are seen as being equally important to the development of that individual. Although the Afrocentric perspective does not deny the importance of the rational, emotions are also seen as playing an essential role in the lives and work of human beings.

The effects of racism as a factor in the treatment of PTSD among African-American college students are becoming more and more evident. Although multiple sociocultural factors related to attitudes, beliefs, and value systems may interact to shape African Americans' experiences in therapy, the underpinnings of society are much more relevant. As mentioned before, racial segregation, both legal and *de facto,* has effectively limited the level and nature of contact between African-American and Caucasian people so that many American Caucasians are not familiar with the life context of their African-American clients. According to Lester (2005), it is imperative that we continue to vigorously explore this topic, as this issue is paramount to the future of African-American health concerns.

PTSD resulting from or exacerbated by race-based trauma may be overlooked by standardized assessments, creating racial disparities in both diagnosis and treatment (Malcoum, Williams, & Bahojb-Nouri, 2015). This leaves a profound gap in the

understanding of trauma as it relates to minority populations, particularly African-American college students to inevitably generate discrepancies in treatment and recovery. Differences to consider may include the race and ethnicity of the clinician and the client, race-related components, and differences in trauma cognitions across race (Carter, 2009).

Turner (2014) describes facts about African-American mental health. These facts may provide barriers that impede upon the wellness of African Americans and their mental health needs:

1. African-American college students in the United States are less likely to receive accurate diagnoses than their Caucasian counterparts are.
2. Culture biases against mental health professionals and health care professionals in general prevent many African Americans from accessing care due to prior experiences with historical misdiagnosis, inadequate treatment, and lack of cultural understanding; only 2% of psychiatrists, two percent of psychologists, and four percent of social workers in the United States are African-American.
3. Mental illness is frequently stigmatized and misunderstood in the African-American community. African Americans are much more likely to seek help through their primary care doctors as opposed to accessing specialty care.
4. African-American college students tend to rely on family, religious, and social communities for emotional support rather than turning to health care professionals, even though the latter tactic may at times be necessary. The

health care providers they seek may not be aware of this important aspect of a person's life.

5. Programs in African-American communities sponsored by respected institutions such as churches and local community groups can increase awareness of mental health issues and resources and decrease the related stigma.

Two organizations have developed programming replication which is warranted at HBCUs. The Jed and Clinton Health Matters Campus Program provides professional development, program evaluation, and technical assistance to colleges and universities. Their multifaceted approach focuses on student mental health, academic performance, wellness, and identifying students at risk for depression and suicide. Similar to the abovementioned program, Active Minds is a national organization with college affiliates throughout North America that encourages students to confront mental illness by providing training and support.

Turner (2014) suggested that as a field of mental health, there is a need to continue to improve the ability to work with diverse cultural groups. Conscious and unconscious bias from providers, a lack of cultural competence, and inadequate respect for culturally responsive approaches results in misdiagnosis and poorer quality of care for African-American college students. Too often decisions about how to meet the mental health needs of African-American college students are made by individuals who do not carry the skill set to make culturally informed decisions; rather, they tend to approach the work from a cookie-cutter standpoint. This type of technique perpetuates the cultural

malpractice that permeates a cycle of inappropriate services, hindering the possibility of improved outcomes (Crowder, 2015).

Summary of Literature Review

Based on research, it is clear that there are common barriers to treatment among various racial and ethnic groups. Turner (2016) concluded that there is substantial evidence on mistreatment and misdiagnosis among African Americans. Studies show that people of color are misdiagnosed with more serious psychological conditions even when they have similar symptoms as white people have. Studies also show that black men are often socialized or grow up in homes where masculinity is emphasized and men are not encouraged to talk about their feelings or emotions (Watkins, Allen, Goodwill, & Noel, 2016). Although the mental health profession has work to do to address barriers to treatment, there must also be a change in the black community to embrace an improved perception of mental health services. Another barrier for mental health treatment is the lack of African-American therapists, as for some individuals, it is important to have a therapist that looks like them and can relate to them (Turner et al., 2016). Given therapists are often white, some African Americans may be more likely to avoid treatment, which may lead to more significant mental health problems the longer that these individuals remain untreated. If we have more providers of color, black men may feel that their experiences are better understood, and therapists may better understand the dynamics faced by black men living in the social and political system of America. Black women have also encountered numerous experiences of racial degradation when seeking adequate treatment for mental health disorders such as PTSD.

The majority of extant literature on trauma found significant differences between African-American and white college students in trauma exposure rates (Pieterse, Carter, Evans, & Walter, 2010). In addition, socioeconomic status (SES), race, and gender correlates with the types of trauma to which children, adolescents, and adults are exposed throughout their lifespan (Basch, 2011; Breslau, Davis, Andreski, & Peterson, 1991; Goodman & West-Olatunji, 2010). For instance, African-American women experience higher rates of interpersonal violence (sexual assault, molestation, and domestic violence) while African-American men are more likely to encounter random acts of violence (such as robberies and stabbings). The long-term implications for African-American students who survive violent communities and attend HBCUs are significant, as HBCUs possess fewer resources compared to PWIs because of historical inequities (Palmer et al., 2011).

It is my belief that older literature can help to create an historical perspective as well as establish a precedence for current events. Older citations tend to construct building blocks that assist in substantiating what was or was not done in the past and try to show progression towards a future goal. Few researchers start from scratch, and because almost all fields of study are more than ten years old, researchers must turn to the literature in better-established fields for support. Doctoral researchers are expected to show that they understand how the problem that they are researching manifested historically. To illustrate, included in the literature review is a citation regarding the unethical medical experiment treatment of poverty-stricken African-American men in Tuskegee, Alabama. This tragedy may have set a precedence as to why black people, particularly black men, have mistrust for some healthcare providers in modern society. It

is imperative for a researcher to know, understand, and correlate the events of the past those of the present, as well as to predict what trends may develop in the future if a historical or contemporary problem is not solved or eradicated.

First, our rationale for advancing this framework around the specific topic of black college student success is rooted in the pressing problem facing HBCUs and all of American higher education. Success can be a struggle for college students of every race and ethnicity across institutions (Arum & Roksa, 2011; Tinto, 2012); however, the struggle for success is particularly acute for too many black-American students. Areas of concern include equitable access to college (Posselt et al., 2012), learning and overall development during college (Kimbrough & Harper, 2006; Museus et al., 2011), and graduation from college (Knapp et al. 2011). Bringing a continuum of global awareness regarding race-based trauma and equity of treatment is essential to making sure the African-American community receives treatment from healthcare personnel who can relate to the them. Of equal importance is ensuring that training is abundant for non-African-American healthcare providers and that African Americans erase the stigma attached to receiving medical attention when needed for physical and mental health issues alike.

Interestingly, the HBCU literature has developed for decades without the benefit of a single theoretical framework that is rooted in these schools and the work they do for black students. The contention is that this has hindered the full depth of assessment, critique, learning, and improvement that could be possible if one such framework was in place. Thus, the objective here is to take a step toward filling this theory gap by

advancing the first HBCU-based theoretical framework in the literature to date. The writer has reviewed and synthesized the relevant HBCU literature to ground the major components of the framework, and has introduced a conceptual model as a visual aid. Also offered by the writer are theoretical reflections on the model. Finally, despite the impressive work of high-achieving black college students (Fries-Britt et al., 2010; Harper, 2012; Jett, 2013; McGee & Martin, 2011; Palmer et al., 2010a), a race-based success gap persists.

Over recent years, numerous scholars have introduced many conceptual contributions of varying sophistication and significance with relevance to black college student success (Arroyo, 2010; Cokley & Chapman, 2008; Fleming et al., 2008; Guiffrida, 2005; Guiffrida, 2006; Kuh & Love, 2000; Kumashiro, 2000; Ladson-Billings, 1995; Museus & Quaye, 2009; Palmer et al., 2011; Steele, 1997; Watkins, 2005). As a result, the literature provides a multifaceted theoretical base for working with this population. However, no existing conceptual work related to black student success deals sufficiently with institutional responsibility. Although the literature does contain comprehensive volumes that address institutional leaders and stakeholders (e.g., Gallien & Peterson, 2005; Museus and Jayakumar, 2012; Rovai et al., 2007), these do not constitute theoretical contributions in either form or function. A theory has particular uses because of its unique properties, such as comprehensiveness, parsimony, connectivity, testability, and heuristic value, together in a single package (Bacharach, 1989; Jaccard & Jacoby, 2009; Shoemaker et al., 2004; Whetten, 1989). In viewing the professional literature of this topic, the theme that emerges in all facets is the fact that inadequate

diagnosis and treatment of African Americans of race-based trauma is prevalent. The literature strongly suggests that due to stigma in the African-American community regarding mental health issues, low income and fear of dealing with healthcare professionals are main issues that hinder African Americans from receiving the type of care that they need and deserve. According to Turner (2014), African-American college students are more likely to rely of the support of family, religious, and social communities for emotional purposes rather than seeking professional help. The decreased volume of ethnically diverse healthcare providers in the field of mental health is alarming and provides a detriment to receiving quality healthcare from those who can relate and speak the same language as the patient can.

Chapter II provides the literature support and the theoretical foundation for this research. It details the key aspects of the research and their connections to previous research studies. Chapter III will discuss the methodology that will be adapted in this study.

CHAPTER III

METHODOLOGY

This chapter describes the methodology employed in the study under the following headings: study site, methods, sample description, and variables (both dependent and independent).

Study Site

The site of the study was the Atlanta University Center Woodruff Library, located in metropolitan Atlanta, Georgia, a state located in the southeastern United States. The metropolitan Atlanta area reflects an urban environment that includes several of the major counties adjacent to the city of Atlanta. The site was chosen because of the size and accessibility to African-American college students. Additionally, the researcher has attended several of the colleges and universities in the metropolitan Atlanta area and fostered relationships with African-American college students as well as faculty members in the study site.

Sample Description

The study utilized a convenience sample consisted of African-American college students currently attending three metropolitan Atlanta colleges and universities. The three colleges and universities chosen for this study serve approximately 30,000 total students.

Methods

This researcher employed a mixed methods approach. The utilization of a quantitative method was employed by distributing 40 questionnaires in person and collecting those completed questionnaires for entrance into a file data base. Also, the utilization of a qualitative method was employed by the researcher by conducting 10 interviews (storytelling and narratives) selected from the pool of respondents from the quantitative portion of the study.

Survey Questionnaire

A survey questionnaire titled "African-American College Students Questionnaire" was developed for this particular study. The self-administered questionnaire included 28 items. The 28 items were divided into four parts: (a) demographics, (b) traumatic experiences, (c) access to mental health services, and (d) academic achievement. Instruction directed respondents to choose only one answer for each question.

After receiving permission to proceed with the survey, the questionnaires were disseminated to the African-American college students in each of the eight colleges and universities. The researcher explained the purpose of the study and distributed the questionnaires. The questionnaire took approximately six minutes to complete. Upon completion, the researcher collected the questionnaires, coded them, and entered them into a computer data file utilizing Statistical Package for Social Sciences (SPSS).

Measurement of the Dependent Variable

Academic achievement is the dependent variable of this study. This variable consists of one broad category: performance-related measures (persistence).

Performance-related measures have three dimensions: (a) those variables related to courses, work ethic and self; (b) those related to other students in the classroom and socialization on campus; and (c) those related to intended goals. Self and work ethic-related work variables refer to question 28 of the questionnaire (i.e., "What is your GPA?"). Other students in classroom and socialization on campus-related variables refer to question 29 of the questionnaire (i.e., "Have you ever been on academic probation while in college?"). Intended goals-related variables refer to question 30 of the questionnaires (i.e., "Do you think you will graduate on schedule from this college?").

All of the responses to the above variables have either two, three, or four categorical options that are coded for measurement purposes in the following manner. For question 28: 1 = between 2.00 and 3.00; 2 = between 3.00 and 4.00; for question 29: 1 = YES, 2 = NO; and for question 30: 1 = YES, 2 = NO, and 3 = NOT SURE.

Measurement of the Independent Variable

Two independent variables were selected for this study: race-related trauma experiences and access to mental health services. Both of the above variables have categorical options that are coded for measurement purposes in the following manner. For questions 10 through 24: 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree. For questions 25 through 27: 1 = YES, 2 = NO.

CHAPTER IV

PRESENTATION OF FINDINGS

This chapter presents both the quantitative and qualitative findings of the study. The results were gathered from a sample of African-American college students attending five metropolitan Atlanta colleges and universities. The quantitative portion sought to answer the main research questions of the study; the qualitative portion was utilized as supplements to support the quantitative findings. Chapter IV includes the following segments: Demographic Information, Summary of Findings, and Conclusions.

Demographic Information

In this study sample, there were 40 African-American participants surveyed. Using descriptive statistics, these demographic questions were summarized in Table 1. Of the participants in this study, 19 (47.5%) were male, and 21 (52.5%) were female. There were 38 (95.0%) unmarried and 2 (5.0%) married participants. In terms of age group, there were 14 (35.0%) participants under the age of 20 (but above 18); 25 (62.5%) were between 20 and 29 years old; and only 1 (2.5%) was between the age of 40 and 49. Of the participants, 3 (7.5%) had been diagnosed with PTSD, and the remaining 37 (92.5%) had not been previously diagnose with PTSD.

Table 1

Demographics of the Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
Gender				
Male	19	47.5	47.5	47.5
Female	21	52.5	52.5	100.0
Total	40	100.0	100.0	
Marital Status				
Never Married	38	95.0	95.0	95.0
Married	2	5.0	5.0	100.0
Total	40	100.0	100.0	
Age Group				
Under 20	14	35.0	35.0	35.0
20-29	25	62.5	62.5	97.5
40-49	1	2.5	2.5	100.0
Total	40	100.0	100.0	
Previous PTSD Diagnosis				
Yes	3	7.5	7.5	7.5
No	37	92.5	92.5	100.0
Total	40	100.0	100.0	

Summary of Quantitative Findings

Research question 1 evaluates if there is a statistically significant relationship between the occurrences of race-related PTSD and African-American college students. Based on the research question, the following hypothesis was constructed:

Ho1: There is a statistically significant relationship between the occurrences of race-related PTSD and African American college students.

To answer this research question, 12 questions were asked based on different scenarios and the participants were asked to rate their agreements to the questions with 1 being “strongly disagree” and 4 being “strongly agree.” Each individual question was summarized by responses (see Tables 2 through 13). From these responses, there were varied responses based on different questions. There was a near even split between the total agreement and disagreements in the responses for these questions (241 for disagree and 239 for agree). There was a noticeable difference in responses for the respondents and their responses regarding their family and friends. Although the respondents did not report race-related traumas to themselves directly, they did report friends and/or family members experiencing these traumas.

Table 2

Traumatic Experience Question 1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	8	20.0	20.0	20.0
	2	14	35.0	35.0	55.0
	3	10	25.0	25.0	80.0
	4	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

Table 3

Traumatic Experience Question 2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	3	7.5	7.5	7.5
	2	9	22.5	22.5	30.0
	3	9	22.5	22.5	52.5
	4	19	47.5	47.5	100.0
	Total	40	100.0	100.0	

Table 4

Traumatic Experience Question 3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	10	25.0	25.0	25.0
	2	14	35.0	35.0	60.0
	3	7	17.5	17.5	77.5
	4	9	22.5	22.5	100.0
	Total	40	100.0	100.0	

Table 5

Traumatic Experience Question 4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	8	20.0	20.0	20.0
	2	10	25.0	25.0	45.0
	3	9	22.5	22.5	67.5
	4	13	32.5	32.5	100.0
	Total	40	100.0	100.0	

Table 6

Traumatic Experience Question 5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	20	50.0	50.0	50.0
	2	15	37.5	37.5	87.5
	3	4	10.0	10.0	97.5
	4	1	2.5	2.5	100.0
	Total	40	100.0	100.0	

Table 7

Traumatic Experience Question 6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	14	35.0	35.0	35.0
	2	13	32.5	32.5	67.5
	3	11	27.5	27.5	95.0
	4	2	5.0	5.0	100.0
	Total	40	100.0	100.0	

Table 8

Traumatic Experience Question 7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	15	37.5	37.5	37.5
	2	16	40.0	40.0	77.5
	3	5	12.5	12.5	90.0
	4	4	10.0	10.0	100.0
	Total	40	100.0	100.0	

Table 9

Traumatic Experience Question 8

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	13	32.5	32.5	32.5
	2	10	25.0	25.0	57.5
	3	9	22.5	22.5	80.0
	4	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

Table 10

Traumatic Experience Question 9

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	7	17.5	17.5	17.5
	2	6	15.0	15.0	32.5
	3	12	30.0	30.0	62.5
	4	15	37.5	37.5	100.0
	Total	40	100.0	100.0	

Table 11

Traumatic Experience Question 10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	2.5	2.5	2.5
	2	9	22.5	22.5	25.0
	3	9	22.5	22.5	47.5
	4	21	52.5	52.5	100.0
	Total	40	100.0	100.0	

Table 12

Traumatic Experience Question 11

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	5	12.5	12.5	12.5
	2	13	32.5	32.5	45.0
	3	11	27.5	27.5	72.5
	4	11	27.5	27.5	100.0
	Total	40	100.0	100.0	

Table 13

Traumatic Experience Question 12

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	3	7.5	7.5	7.5
	2	5	12.5	12.5	20.0
	3	9	22.5	22.5	42.5
	4	23	57.5	57.5	100.0
	Total	40	100.0	100.0	

Research question 2 sought to answer if there were significant statistical differences between male and female African-American college students in terms of the incidences of race-related PTSD. The same 12 questions from the previous research questions were analyzed by group differences using independent sample t-tests.

Ho2: There is a significant statistical difference between male and female African-American college students in terms of the incidences of race-related PTSD.

Independent sample t-tests were used because quantitative responses were compared between two categories – male and female. The results presented in Table 14 summarize the test outcome. There were two significant test outcomes which were question 12 – "As a result of my family members experiencing racial profiling, the event caused them to become easily upset and/or defensive," and question 21 – "I was traumatized by the confederate flag being flown in certain states."

Table 14

Summary of Independent Samples t-Test Results for Questionnaire Questions

		Levene's Test		t-test for Equality of Means				
		F	Sig.	t	df	Sig. (2-tailed)	Mean Diff	S.E. Diff
Q11	Equal variances assumed	.183	.671	.744	38	.461	.246	.330
	Equal variances not assumed			.742	37.116	.463	.246	.331
Q12	Equal variances assumed	19.714	.000	-2.282	38	.028	-.692	.303
	Equal variances not assumed			-2.223	27.842	.035	-.692	.311
Q13	Equal variances assumed	2.965	.093	-.895	38	.376	-.313	.350
	Equal variances not assumed			-.905	37.547	.371	-.313	.346
Q14	Equal variances assumed	.009	.925	-1.063	38	.294	-.383	.361
	Equal variances not assumed			-1.065	37.773	.294	-.383	.360
Q15	Equal variances assumed	4.327	.044	-1.844	38	.073	-.436	.237
	Equal variances not assumed			-1.894	31.909	.067	-.436	.230
Q16	Equal variances assumed	.309	.582	-1.203	38	.236	-.348	.289
	Equal variances not assumed			-1.198	36.605	.239	-.348	.291

(continued)

		Levene's Test		t-test for Equality of Means				
		F	Sig.	t	df	Sig. (2-tailed)	Mean Diff	S.E. Diff
Q17	Equal variances assumed	.182	.672	-.343	38	.734	-.105	.307
	Equal variances not assumed			-.342	37.171	.734	-.105	.308
Q18	Equal variances assumed	2.734	.106	-1.930	38	.061	-.672	.348
	Equal variances not assumed			-1.951	37.537	.059	-.672	.344
Q19	Equal variances assumed	1.173	.286	-1.031	38	.309	-.363	.352
	Equal variances not assumed			-1.046	36.959	.303	-.363	.348
Q20	Equal variances assumed	.064	.801	-1.715	38	.095	-.476	.278
	Equal variances not assumed			-1.714	37.520	.095	-.476	.278
Q21	Equal variances assumed	3.567	.067	-2.038	38	.049	-.632	.310
	Equal variances not assumed			-2.008	33.227	.053	-.632	.314
Q22	Equal variances assumed	.423	.519	-1.569	38	.125	-.471	.300
	Equal variances not assumed			-1.565	37.199	.126	-.471	.301

Question 12 relates to the racial profiling experiences of the participants' family members, and therefore it will not be considered to answer the research question. Question 21 directly related to the respondents. The test statistics showed that there is a significant difference between male and female participants in terms of being traumatized by the confederate flag being flown in certain states (t=-2.04, p=.049). From these results, it can be concluded that the null hypothesis was rejected, and male participants were less agreeable (traumatized) by the confederate flag being flown in certain states by female participants.

Research question 3 was designed to investigate whether there is a statistically significant relationship between the incidence of race-related PTSD and the household income of the African-American participants. A Pearson's correlation matrix was utilized to answer this research question because a relationship between two continuous variables was examined. There were two pairs of significant pairs of correlations which were question 12 – "As a result of my family members experiencing racial profiling, the event caused them to become easily upset and/or defensive." and question 13 – "I have experienced racial bias by high school teachers and college professors of another race, causing me to feel a lack of initiative or a lessened desire to succeed academically since the event."

Ho3: There is significant statistical relationship between participant household income and the incidences of race-related PTSD.

Both of the correlations were negative, which indicates that participants from higher household income homes tend to have lower agreement on the PTSD scale. Since only question 13 was directly related to the participants themselves and question 12 was not, question 13 was the primary focus. The results ($r=-.346$, $p=.029$) indicated that participants from higher household income homes tend to feel less traumatized by the experiences of racial bias in school (see Table 15).

Research question 4 asked the extent to which the African-American participants who were affected by race-related PTSD had access to treatment. A series of descriptive statistics were conducted in order to answer this research question.

Table 15

Pearson's Correlation between Household Income and Race-Related PTSD

		Q6
Q11	Pearson Correlation	-.091
	Sig. (2-tailed)	.578
	N	40
Q12	Pearson Correlation	-.104
	Sig. (2-tailed)	.523
	N	40
Q13	Pearson Correlation	-.346*
	Sig. (2-tailed)	.029
	N	40
Q14	Pearson Correlation	-.340*
	Sig. (2-tailed)	.032
	N	40
Q15	Pearson Correlation	-.154
	Sig. (2-tailed)	.342
	N	40
Q16	Pearson Correlation	-.075
	Sig. (2-tailed)	.647
	N	40
Q17	Pearson Correlation	.127
	Sig. (2-tailed)	.435
	N	40
Q18	Pearson Correlation	.103
	Sig. (2-tailed)	.527
	N	40

(continued)

		Q6
Q19	Pearson Correlation	.211
	Sig. (2-tailed)	.191
	N	40
Q20	Pearson Correlation	-.043
	Sig. (2-tailed)	.793
	N	40
Q21	Pearson Correlation	.127
	Sig. (2-tailed)	.434
	N	40
Q22	Pearson Correlation	-.118
	Sig. (2-tailed)	.468
	N	40

Of the participants, 31 (77.5%) responded that they have never sought counseling services at their school to address the impact of race-related traumatic experience although 34 (85%) participants were aware that such services were made available to students. The perceptions of the usefulness of the counseling services were evenly distributed, which indicates that the participants hold a neutral opinion towards the effectiveness of counseling for race-related trauma (see Tables 16 through 18).

Table 16

Counseling Services

Have you sought counseling services at your college to address the impact of the race-based traumatic experiences?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	9	22.5	22.5	22.5
	No	31	77.5	77.5	100.0
	Total	40	100.0	100.0	

Table 17

Helpfulness of Counseling

Do you think that such counseling would be helpful?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	23	57.5	57.5	57.5
	No	17	42.5	42.5	100.0
	Total	40	100.0	100.0	

Table 18

Access to Mental Health Care

If needed, do you have access to mental health care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	34	85.0	85.0	85.0
	No	6	15.0	15.0	100.0
	Total	40	100.0	100.0	

Research question 5 was intended to examine if there is a statistically significant relationship between race-related PTSD and academic achievement among African-American participants in this study.

Ho5: There is a significant statistical relationship between participant academic performances and the incidences of race-related PTSD.

Another Pearson's correlation was run to analyze the relationship between race-related PTSD questions and participants' GPA since they were both quantitative and continuous variables. Of the 12 questions used to compare with GPA, none showed significant correlations. This indicates that academic performance was not related to the experiences of race-related traumatic experience in the participants in this study (see Table 19).

Table 19

Correlation between Academic Performance and Race-Related PTSD

		Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21	Q22
Q26	Pearson Correlation	-.193	.057	-.160	-.206	-.110	-.063	-.261	.051	-.026	.100	.123	.032
	Sig. (2-tailed)	.267	.747	.357	.236	.529	.720	.130	.773	.881	.569	.482	.853
	N	35	35	35	35	35	35	35	35	35	35	35	35

Summary of Qualitative Findings

There were eight questions included in the qualitative portion of the study. These questions further investigated the lived experiences of race-related PTSD among participants in the study. The responses are used to support the quantitative findings and further illustrate the effects of race-related PTSD on participants. An invitation was

shown at the end of each survey for the participation of the narrative portion of the questionnaire. Participation was completely voluntary. Of the 40 participants in the sample, 10 consented to the qualitative segment of the study. Their responses top these 8 questions can be summarized below:

Question 1: How were you affected by the experience of racial profiling by law enforcement?

There were five participants (two females and three males) that reported they had never experienced racial profiling by law enforcement. There were five participants (four females and one male) that reported they have experienced racial profiling by law enforcement.

Highlighted Responses: *I could be killed next* and *officer drew his weapon on me.*

Question 2: How were you affected by the experience of racial bias by high school teachers and college professors of another race?

There were five participants (three females and two males) who reported that they had never experienced racial bias by high school teachers or college professors of another race. There were five participants (three females and two males) that reported they have experienced racial bias by high school teachers and college professors of another race.

Highlighted Responses: *I was taken back at first but then I began to fight it by setting up ways for students to cope with these experiences* and *High school teacher told me if I did not do well, I'd end up in a ghetto school like Morgan State.*

Question 3: How were you affected by the experience of racially motivated prejudice while being treated in a hospital?

There were nine participants (five females and four males) who reported that they had never experienced racially motivated prejudice while being treated in a hospital. There was one female participant who reported that she had experienced racially motivated prejudice while being treated in a hospital.

Highlighted Response: *My brother was discharged from the hospital without adequate treatment after a bad accident. He is still trying to recover a year later*.

Question 4: How were you affected by the experience of discriminatory hiring practices while interviewing for jobs?

There were nine participants (five females and four males) who reported that they had never experienced discriminatory hiring practices while interviewing for jobs. There was one female participant who reported that she had experienced discriminatory hiring practices while interviewing for jobs.

Highlighted Response: *Made me feel as though I wasn't good enough for the job.*

Question 5: How were you affected by experiencing the racially motivated shootings in the South Carolina A.M. E. church?

There was only one male participant who reported that he was not affected by experiencing the racially motivated shootings in the South Carolina A.M. E. church. There were nine participants (six females and three males) who reported they were affected by experiencing the racially motivated shootings in the South Carolina A.M. E. church.

Highlighted Response: *It has caused me to be fearful of just walking outside. I was hurt. I felt afraid for my family and people because we were no longer safe in our safe space, the church. The experience from the South Carolina AME church made me realize that at the blink of an eye anything can happen. It made me cautious of my surroundings and also fearful of white citizens for a while.*

Question 6: How were you affected by the recent killings of black males (Trayvon Martin, Michael Brown, Orlando Castillo and Tamir Rice) by white police officers?

There was only one male participant who reported that he was not affected by the recent killings of black males (Trayvon Martin, Michael Brown, Orlando Castillo and Tamir Rice) by white police officers. There were nine participants (six females and three males) who reported that they were affected by the recent killings of black males (Trayvon Martin, Michael Brown, Orlando Castillo and Tamir Rice) by white police officers.

Highlighted Quotes: *Made me realize that the court system & police do not care about our black men or their futures. I have two sons. I pray daily for their safety from trigger happy white cops. The killings of these black men have made me fearful of police officers.*

Question 7: How were you affected by the confederate flag being flown in certain states?

There was only one female participant who reported that she was not affected by the confederate flag being flown in certain states. There were nine participants (five

females and four males) who reported that they were affected by the confederate flag being flown in certain states.

Highlighted Responses: *Seeing this flag makes me angry. I think of all my ancestors that died behind that flag. It is an offensive symbol that represents white supremacy. I lived in a white rural-suburban community, so I saw the flag a lot and every time I saw it, I was baffled. How can people be so proud to have a flag that brings so much pain to my people.*

Question 8: How were you affected by the violent acts committed towards blacks by white supremacists and other hate groups?

There was only one male participant who reported that he was not affected by the violent acts committed towards blacks by white supremacists and other hate groups. There were nine participants (six females and three males) who reported that they were affected by the violent acts committed towards blacks by white supremacists and other hate groups.

Highlighted Responses: *It makes me very angry. It makes me want to get back at them for what they have done and continue to do to my people. Made me realize racism is an issue with no resolution and those who try to ignore do not see events like this. This affected me because I became fearful of being a black man in the USA with the possibility of being targeted.*

Conclusion

The purpose of this study was to examine the relationship between race-based trauma and PTSD among African Americans and to explore stressors related to PTSD.

Participants in the study were African-American college students residing in the Metropolitan Atlanta area. Descriptive statistics, independent samples t tests, and Pearson's correlation tests were utilized in answering the quantitative research questions. The results have shown that there was a gender difference in perceiving the race-related trauma; household income level also negatively relates to the degree of trauma experienced by participants. On the other hand, academic performance and the willingness to seek counseling were not affected. For the qualitative aspect of the study, most participants reported that although they did not personality experience race-related trauma, it is understood that it happens to others.

Chapter IV summarized the results of the study based on the data collected. An in-depth discussion regarding the implications, limitations, and recommendations for future studies is presented in Chapter V.

CHAPTER V

DISCUSSION AND IMPLICATIONS OF THE FINDINGS

The purpose of Chapter V is to provide discussion and implications of the findings described in Chapter IV which resulted from the implementation of the data collection and data analysis procedures described in Chapter III. In this chapter, findings in this study are related to current theory and literature on the study's topic. This chapter begins with a brief summary of the study, including its background, purpose, and procedures. Next, this chapter proceeds with a summary of the findings and integration with the literature, followed by a discussion of study limitations. Lastly, this chapter includes conclusions based on the findings and an explanation of how the findings can be used to enhance the discipline.

The widespread and substandard scholastic attainment of African-American students in the United States is an ongoing and unresolved concern for counselors and educators (Orfield, Losen, Wald, & Swanson, 2004). Efforts to address academic underachievement have traditionally conceptualized underperformance as the result of a child's personal or cultural deficits (Ford, Harris, Tyson, & Trotman, 2002; Wycoff, 1996). Additionally, educators have long ascribed symptoms in African-American students of traumatic stress (such as exaggerated startle responses, flat affect or diminished interest, withdrawing from peers, and thoughts or feelings that disrupt normal activities) to these perceived deficits (Elliott, 1997; Graham-Bermann & Levendosky,

1998). However, traumatic stress theory explains the effects that ecosystemic factors such as hegemony, the dominance of one social group over another, may have on an individual's functioning (Carlson, 1997; Carter, 2007). Scholarship on hegemony and traumatic stress exposes the many barriers that African-American individuals face in society by demonstrating the mental and physical health effects of discrimination (Goodman & Frazier, 2015).

Carter (2007) proposed a non-pathological model of traumatic stress referred to as race-based traumatic stress and injury. Carter defined a racial trauma as an event that evokes emotional or physical pain (or the threat of pain) and that results from racism in forms of racial harassment, racial discrimination, or discriminatory harassment. Carter (2013) suggested that for a racial encounter to be traumatic, it must be experienced as sudden, out of one's control, and highly negative. Symptom clusters typically include intrusions, arousal, avoidance, anxiety, anger, depression, low self-esteem, shame, and guilt. Although Carter's measure is currently the only measure of race-based traumatic stress, a number of researchers have linked discrimination to psychological distress for socially marginalized individuals (LeBlanc, Frost, & Wight, 2015). Examining the influence of discrimination within the construct of traumatic stress can serve to legitimize individuals' psychological reactions to hegemony (Villatoro, Mays, Ponce, & Aneshensel, 2017). Thus, the purpose of this study was to examine the relationship between race-based trauma and PTSD among African Americans and to explore stressors related to PTSD.

This researcher employed a mixed methods approach. The utilization of a quantitative method was employed by distributing 40 questionnaires to African-American students in the Metropolitan Atlanta area in person and collecting those completed questionnaires for entrance into a file database. Academic achievement was the dependent variable in this study. Two independent variables were selected: race-related trauma experiences and access to mental health services. Descriptive statistics, independent samples t tests, and Pearson's correlation tests were utilized in answering the quantitative research questions. A qualitative method was employed by conducting interviews with 10 participants selected from the pool of respondents from the quantitative portion of the study. Participants' responses to the eight qualitative interview questions were analyzed thematically.

Summary of the Findings and Integration with the Literature

This section is organized by research question, with the answers to each quantitative research question discussed separately. Discussion of the qualitative findings follows. Within each sub-section, the findings in the study are summarized, and the findings are evaluated to determine their consistency or inconsistency with current theory and literature on the topic of race-related trauma in African-American students.

RQ1: Is there a statically significant relationship between the occurrences of race-related PTSD and African-American college students?

Research question 1 was designed to evaluate the extent to which African-American college students experience race-related PTSD. Although the respondents did not report race-related traumas to themselves directly, they did report friends and/or

family members experiencing these traumas. In the literature (Carter, 2007), race-based traumatic stress has been defined as (a) an emotional injury that is motivated by hate or fear of a person or group of people as a result of their race, (b) a racially motivated stressor that overwhelms a person's capacity to cope, (c) a racially motivated interpersonal severe stressor that causes bodily harm or threatens one's life integrity, or (d) a severe interpersonal or institutional stressor motivated by racism that causes fear, helplessness, or horror. Racial trauma is the physiological, psychological, and emotional damage that result from harassment and/or discrimination (Villatoro et al, 2017). According to Carter (2007), it is based in the established evidence that demonstrates that racial discrimination and harassment in the context of racism are stressors for their targets.

Studies have shown that African-American college students report higher likelihood of trauma exposure and the development of PTSD when compared to other ethnic groups (Ai et al., 2011; McGruder-Johnson, Davidson, Gleaves, Stock, & Finch, 2000). Additionally, many critical race scholars acknowledge that African Americans and students from other historically marginalized groups often endure subtle but constant forms of discrimination and bias (Andrews & Tuitt, 2013). Counter-narratives of everyday experiences at traditionally white institutions regularly expose these institutions' denial that covert bias exists on their campuses. Marginalized students endure a plethora of racial assaults, which contribute to mental fatigue and psychological distress.

Findings in this study were inconsistent with previous research insofar as they indicated an absence of race-related trauma in participants. However, this apparent inconsistency with previous literature indicating the high prevalence of trauma in African-American college students may in part be explained by participants' attendance at historically black colleges and universities (HBCUs). Since their inception, HBCUs have provided a nurturing environment for African-American students in spite of economic, educational, political, and social disparities, and it may be the case that participants in this study were to some extent protected from race-related trauma by their attendance at such institutions (Walker, 2015). Walker, for example, found that HBCUs insulate their students from external stressors that may cause trauma. In relation to this proposed explanation of the apparent disparity between the finding and the literature, it is significant that participants in this study reported that friends and family members had experienced trauma. Thus, while participants in this study may have been somewhat insulated from traumatic experiences by their attendance at HBCU, they had observed the prevalence of trauma in persons close to them.

RQ2: Is there a statistically significant difference between male and female African-American college students in terms of incidences of race-related PTSD?

Research question 2 asked whether there were differences between male and female African-American students in terms of the incidences of race-related PTSD. The findings showed that there is a significant difference between male and female participants in terms of being traumatized by the confederate flag being flown in certain states, with male participants reporting a lower level of trauma. This finding was

consistent with previous literature indicating differential effects of mental illness on African-American women versus African-American men.

Baker, Buchanan, and Spencer (2010) conducted a study that revealed a combination of health issues differentially affects the behavioral, psychological, and physical well-being of African-American women. The researchers maintain that these disparities are both the result of and contributors to marked differences in the perception, interpretation, and treatment of various psychological disorders and chronic medical conditions. According to Primm (2016), who has worked in the area of health disparities as it relates to African Americans for decades, co-founding a treatment program that provided in-home mental health treatment to patients, PTSD diagnoses are more common in women than in men, and that disparity holds true in African-American communities.

Samuels-Dennis et al. (2010) suggested that mental health is determined by macro-level factors (neighborhood structural and political characteristics) that intersect to shape power inequalities, discriminating social relations, and the distribution of health and social resources. As a result, according to Samuels-Dennis et al. (2010), these intersecting factors facilitate a meso-level trauma-PTSD process whereby gender-based trauma—non-naturally occurring traumatic experiences that are motivated and supported by entrenched beliefs about the socially ascribed roles, responsibilities, and locations of individuals belonging to the male and female sexes—directly and disparity impacts women's and men's mental health and well-being through its influence on women's personal resources (agency), social resources (formal support/resources), and trauma-induced interpersonal stressors (social strain). The finding in the present study that

women have experienced more race-related trauma than men is consistent with the aforementioned literature and may potentially be explained by the intersectional factors described by Samuels-Dennis et al. (2010), indicating that African-American women may suffer trauma as a result of race- and gender-related discrimination and experiences.

RQ3. Is there a statistically significant relationship between race-related PTSD and the household income of African-American college students?

Research question 3 was designed to investigate whether there is a relationship between the incidence of race-related PTSD and the household income of the African-American participants. The results indicated that participants from higher household income homes tend to feel less traumatized by the experiences of racial bias in school. This finding was consistent with previous literature, some of which may furnish and explanation for economically differential effects of trauma.

The differential vulnerability model (Ulbrich, Warheit, & Zimmerman, 1989) suggests that African Americans, especially those from a lower socioeconomic class, are disadvantaged for two reasons. First, they are more likely to live in at-risk areas and thus will be exposed to greater numbers and more severe types of trauma (differential exposure). Second, they are less likely to have access to financial and social resources; therefore, they are more vulnerable to the impact of negative life events regardless of the level of exposure (differential vulnerability). Although few studies have focused on trauma exposure and PTSD among African-American college students, the results of such studies have generally supported the differential vulnerability hypothesis, finding heightened risk of both trauma exposure and PTSD for African-American students (e.g., Ai et al., 2011; McGruder-Johnson et al., 2000). The finding in this study is consistent

with this literature and is potentially explained by factors such as differential exposure and differential vulnerability.

RQ4: Is there a statistically significant relationship between race-related PTSD and access to treatment among African-American college students?

Research question 4 was designed to investigate the extent to which the African-American participants who were affected by race-related PTSD had access to treatment. Of the participants, 31 (77.5%) responded that they have never sought counseling services at their school to address the impact of race-related traumatic experience, although 34 (85%) participants were aware that such services were made available to students. The perceptions of the usefulness of the counseling services were evenly distributed, which indicated that the participants hold a neutral opinion towards the effectiveness of counseling for race-related trauma. Both findings—that participants had not sought help, and that participants overall had a neutral perception of the efficacy of available counseling services—are significant but are related to the literature in different ways.

The finding that most participants had not sought counseling services at their school to address the impact of race-related traumatic experience is consistent in the first place with the finding that participants did not perceive themselves as having experienced race-related trauma. However, the finding is also consistent with findings in the literature related to the underutilization of mental health services by African Americans. African-American college students have relied on a gamut of resources to address mental health problems, but they refrain from bringing sensitive matters like mental health issues to a system that has historically been less than sensitive to the institutional and systemic

challenges African Americans typically endure. The most common barriers are the significance of family privacy; deficit of awareness regarding available treatments; denial of mental health problems; and concerns about stigma, medications, and treatment (Ayalon & Alvidrez, 2007). Krishan et al. (2016) stated that, according to the National Comorbidity Survey (NCS) and the National Comorbidity Survey-Replication (NCS-R), among those with a mental disorder, African Americans are half as likely as white peoples are to receive psychiatric treatment when controlling for the severity of the disorder. African-American college students are also less likely than those of other racial/ethnic groups to receive treatment for a mental disorder through specialty mental health or general medical services.

Explanations for the underutilization of mental health services by African-American college students may be found in the literature, but many of these explanations are inconsistent with the finding in the present study that participants had neutral perceptions of the counseling services in their institutions. The theme of the therapist as prying too deep into the lives of African-American clients has been discussed as a major factor contributing to the reluctance of African Americans entering treatment and prematurely discontinuing therapy. These factors may have contributed to ambivalence and to the higher rate of African-American participants never starting treatment after enrollment in the study or dropping out before completing the protocol. If comfort and trust have not been established in the therapy setting, it can be potentially difficult for many African-American clients to open up and begin telling their life stories to someone who is perceived as an outsider of their community (Boyd-Franklin, 2003).

Perceptions among African-Americans that mental health services are unlikely to help them may have some basis in the discriminatory practices and perceptions of providers. According to Michalec and colleagues (2014), a provider harboring a bias against a certain group may expend minimal effort on behalf of a member of that group, leading to discrimination. Discrimination can also derive from the negative stereotypes a provider might consider as true. For example, Michalec et al (2014) state that if a doctor has the perceptions that "blacks are less likely than whites to comply with treatment," the doctor might prescribe differently based on race for otherwise similar patients. Many white Americans harbor negative stereotypes against black people. Van Ryn and Burke (2000) argue that "physicians may be especially vulnerable to the use of stereotypes in forming impressions of patients since time pressure, brief encounters, and the need to manage very complex tasks are common characteristics of their work."

Providers may discriminate not only against patients of some races but may also take a discriminatory attitude toward experiences that are of significance to persons of the patient's race, but not to persons of the provider's race. Thus, many clinicians only recognize racism as trauma when an individual experience a discrete racist event such as a violent hate crime. This is limiting given that many minorities experience cumulative experiences of racism as traumatic, with perhaps a minor event acting as "the last straw" in triggering trauma reactions (Carter, 2007).

Additionally, psychological difficulties attributed to racist incidents are often questioned or minimized, a response that only perpetuates the victim's anxieties. Thus, patients who seek out mental healthcare to address race-based trauma may be further

traumatized by micro-aggressions, subtle racist slights, from their own clinicians when they encounter disbelief or avoidance of racially charged material (Williams & Leins, 2016). In this study, participants indicated neutral perceptions of the efficacy of the counseling services that were available to them. Their tendency not to use those services may be explained by their perceived lack of race-related trauma. However, their neutral perceptions of counseling services suggested that participants did not view those services as likely to be biased against them, or as likely to underserve them through cultural insensitivity, although the literature has indicated that these possibilities exist.

RQ5: Is there a statistically significant relationship between race-related PTSD and academic achievement among African-American college students?

Research question 5 was intended to examine the relationship between race-related PTSD and academic achievement among African-American participants in this study. Findings indicated that academic performance was not related to the experiences of race-related traumatic experience in the participants in this study. This finding was inconsistent with the literature.

In past studies, African-American college students have reported greater perceived racial hostility, faculty racism, unequal treatment by faculty and staff, and pressure to conform to racial stereotypes than white and Latino students report (Juang et al, 2016), suggesting that trauma-exposed African-American students may face additional stressors and PTEs during college, and these factors in turn may place them at a higher risk for academic difficulties due to increased distress. These risk factors—specifically, the high prevalence of trauma exposure and PTSD among African Americans—may be

one of the contributing factors to the racial disparity in college graduation rates (Lynch & Engle, 2010).

Additionally, African-American college students may feel pressured to win white approval as a means of gaining entry to the middle class, and this pressure has been shown to be maladaptive and can lead to stress, isolation, and anxiety due to the constant pressure to choose between conforming to the dominant culture or remaining true to one's own ethnicity (Navarette and Jenkins, 2011). African-American students who see a contradiction between their second-class status and their high academic achievement often suffer internal strife and may pay a high psychological price for their academic success. These students also may have difficulty with the third aspect of the Du Boisian "veil," where they struggle with the consequences of seeing and situating themselves outside of what the dominant group describes, defines, and prescribes for them (Du Bois, 2007). The finding in the present study was inconsistent with the aforementioned literature, as it indicated no association between the experience of race-related trauma and academic achievement. As with the finding related to research question 1, this finding may potentially be explained by the protective and insulating quality of HBCUs, as described by Walker (2015).

Qualitative Findings

Qualitative findings indicated that many of the 10 interviewees had either directly or vicariously experienced race-related traumas. Although nine out of 10 participants reported that they had not experienced racial discrimination in a medical setting or in hiring practices while interviewing for a job, other responses indicated that significant

traumas were prevalent among members of the qualitative sample. For example, five out of 10 participants had been racially profiled by law enforcement, and at least two participants had feared they would be killed as a result of the incident. Additionally, nine out of 10 participants reported that they were negatively affected by the racially motivated shootings in the South Carolina A.M. E. church, with participants describing themselves as "hurt," "afraid," "cautious of my surroundings," "fearful of white citizens," and realizing "that in an eye blink, anything can happen," responses that are consistent with the experience of trauma.

These findings were consistent with previous literature. As discussed above, Carter (2007) defined race-based traumatic stress as (among other definitions) an emotional injury that is motivated by hate or fear of a person or group of people as a result of their race, and as a severe interpersonal or institutional stressor motivated by racism that causes fear, helplessness, or horror. The responses of the participants are consistent with these definitions, indicating that race-related trauma may be present in these college students.

Limitations of the Study

A significant limitation in this study was the reliance on the honesty and accuracy of participants' responses. While the researcher attempted to acquaint participants with the purpose and potential benefits of this research, and at the same time assured participants that their identities would remain confidential to encourage honesty. Participants may have been influenced by cultural messages indicating that race-related traumatic experiences are not significant or should be deemphasized to avoid provoking

reactions of deprecation or disbelief (see e.g. Williams & Leins, 2016). Additionally, while care was taken in selection of the data collection instrument to ensure that the needed data were elicited, it is possible that use of a different data collection instrument and a completely random sampling method in the quantitative portion of the study would have yielded different findings.

The limited geographic scope of the study may limit generalizability, as may the study's focus on college students. The choice to include only college students resulted in an emphasis on the experiences of the generation that is now of traditional college age, and experiences of race-related trauma may vary greatly between generations. Additionally, experiences of race-related trauma may vary significantly between institutions and between types of institutions (e.g. HBCUs versus predominantly white institutions). Furthermore, the focus on college students may have caused persons of higher than average socioeconomic status to be overrepresented in the sample, again limiting generalizability beyond the population of college students. Lastly, only African-American college students were included in the convenience sample. College students of other races and ethnicities were not included in the scope of this study, and their experiences may vary significantly from those represented in the findings discussed above.

Conclusions Based on the Findings

Quantitative findings in this study indicated that participants had not experienced significant race-related trauma directly, and that any such trauma they had experienced had not negatively impacted their academic achievement. Qualitative findings were

somewhat contrary to those derived from the quantitative instrument, however, in indicating that a significant number of participants had experienced race-related incidents in which they had felt that their lives were immediately or potentially threatened, an experience consistent with definitions of trauma. Additionally, most participants indicated that they had not sought counseling services as a result of these or other, related experiences.

In light of these findings, it is the opinion of the researcher that the assimilation of the concept of race-related trauma into public discourse is needed, as a means of legitimizing and placing due significance on experiences that may indeed be traumatic (such as having a police officer draw a gun to threaten one, as happened to one participant), but which African Americans and other persons of color may have learned to deemphasize, ignore, or accept as an irremediable part of their experience. When public or private events that are expressions of racial hegemony cause individuals to fear for their own lives and to fear their fellow citizens, a legitimate need for discussion, intervention, and remediation exists. When innocent individuals feel afraid for their lives in the absence of any immediate threat, this is a symptom consistent with trauma; when participants' experiences are viewed in this light, it is alarming that most of them reported they had not sought counseling services and did not perceive themselves as traumatized.

The first step in addressing race-related trauma, then, may need to be a raising of awareness among victims, validating their experiences, and helping them to realize that their fears are legitimate effects of racial oppression. To facilitate this awareness-raising,

it is imperative that researchers continue to explore factors that may lead to mental health problems among African Americans, as this issue is paramount to the future of African-American college students and their health concerns. This researcher would affirm the assertion of Carter (2007), to the effect that only education, prevention, intervention, and justice can work against the insidious and tenacious nature of racial oppression, victim-blaming, and pathologizing.

Implications for the Discipline

Findings in the present study suggested that African-American students may not be aware of cultural bias against mental health professionals but may nevertheless underutilize counseling services when a legitimate need exists. It is therefore recommended that college counselors who serve African-American students conduct outreach work to familiarize these students with race-related trauma and its potential effects, to counteract a pervasive delegitimization of valid and potentially disruptive experiences that may prevent students from seeking the help they need. In addition to conducting informational and awareness-raising outreach, it is imperative that mental health professionals address the need for culturally sensitive care.

The literature provides some guidance on how more culturally sensitive care might be achieved. Researchers such as Carter (2007) have examined the need for: (a) counselor training on race-based trauma, (b) recognition of the parallels between PTSD and race-based trauma, (c) validation of a separate category for race-based trauma, (d) examination of racism as an additional trauma for survivors of other forms of trauma, (e) cultural competent assessment and intervention for race-based traumatic stress,

(f) acknowledgement of the intersection between race-based trauma and other forms of societal traumas, and (g) the need to extend psychologists' lens to include international cases of race-based trauma.

Carter (2007) noted that all counselors, including counselors in training and those who entered the field prior to the implementation of cultural competence training requirements, need to receive education on race-based traumatic stress. This education needs to include definitions of race, racism, and race-based traumatic stress as well as assessment needs, effects, and intervention strategies for race-based traumatic stress. There must be education on cultural traditions; the teaching of skills for culturally appropriate interventions; and the fostering of an understanding of power, privilege, and racial oppression. A grasp of these concepts is critical to a counselor's ability to recognize, acknowledge, and address race-based traumatic stress.

The need for such training for counselors may be particularly urgent to counteract cultural bias among mental health professionals among African Americans. Cultural biases against mental health professionals and health care professionals in general prevent many African Americans from accessing care due to prior experiences with historical misdiagnosis, inadequate treatment, and lack of cultural understanding; only two percent of psychiatrists, two percent of psychologists, and four percent of social workers in the United States are African-American (Turner, 2014). These disparities can have negative consequences on the establishment of rapport between provider and patient, so additional efforts must be made to ensure a relationship of trust and confidence is created. If comfort and trust have not been established in the therapy

setting, it can be potentially difficult for many African-American clients to open up and begin telling their life stories to someone who is perceived as an outsider of their community (Boyd-Franklin, 2003).

A practical approach to addressing some of these issues might be for clinicians to spend time prior to or early in treatment building rapport and discussing cultural differences. Setting expectations, taking time to socialize patients to the therapy process, and clearly explaining the rationale for therapy assignments that may be culturally or personally unfamiliar are all tactics that have the potential to make a difference. It is the recommendation of the researcher, therefore, that mental health professionals who serve student bodies that include African Americans engage in informational and awareness-raising activities regarding race-related trauma, and that these professionals implement the practices recommended in the literature to ensure that African-American college students who seek help have their needs respected and met in a culturally sensitive manner.

APPENDIX A

Quantitative Survey

A Study of the Prevalence of Race-Related Post Traumatic Stress Disorder Experiences, Access to Treatment, and Impact on Academic Achievement among African American College Students

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Section I: Demographic Information

Instructions: Check (x) the appropriate answer below. Choose only one answer for each question.

1. Gender: □ Male □ Female □ Transgender
2. Marital Status: □ Never Married □ Married □ Divorced □ Widowed
3. My Age Group: □ Under 20 □ 20-29 □ 30-39 □ 40 and over
4. My Education: College: □ Freshman □ Sophomore □ Junior □ Senior
5. Ethnicity: □ African American □ Caucasian/White □ Hispanic □ Asian □ Other
6. Parents' Annual Income: □ Under $30,000 □$30,000–34,999 □ $35,000 –39,999 □ $40,000 – 49,999 □ $50,000 up
7. Previous PTSD Diagnosis: □ Yes □ No
8. Have you served in the military? □ Yes □ No

9. Are you an American citizen? □ Yes □ No

10. In which state did you complete your high school education? _____

Section II. Traumatic Experiences

Instructions*: Write the number indicating your answer (1 thru 4) in the blank space in front of each statement on the questionnaire. Choose only one answer for each item and respond to all the statements.*

1= Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Agree

Racial Encounters

_____ 11. I have experienced racial profiling by law enforcement which has caused me to be emotionally upset when I am reminded of the event.

_____ 12. As a result of my family members experiencing racial profiling, the event caused them to become easily upset and/or defensive.

_____ 13. I have experienced racial bias by high school teachers and college professors of another race, causing me to feel a lack of initiative or a lessened desire to succeed academically since the event.

_____ 14. One of my family members experienced racial bias by high school teachers and college professors of another race, causing them to feel as though they seldom do anything right.

_____ 15. I have experienced racially motivated prejudice while being treated in a hospital.

_____ 16. One of my family members experienced racially motivated prejudice while being treated in a hospital.

_____17. I was traumatized by discriminatory hiring practices while interviewing for jobs.

_____18. One of my family members was traumatized by discriminatory hiring practices while interviewing for jobs.

_____19. I was traumatized by the racial shootings in the South Carolina A.M.E. church.

_____20. I was traumatized by the recent killings of Black males by white police officers (For example: Trayvon Martin, Michael Brown, Orlando Castillo, and Tamir Rice).

____ 21. I was traumatized by the confederate flag being flown in certain states.

_____22. I was traumatized by the violent acts committed towards Blacks by White supremacists and other hate groups.

III. **Access to Mental Health Services**

Instructions*: Write the number indicating your answer (1 or 2)) in the blank space in front of each statement on the questionnaire. Choose only one answer for each item and respond to all the statements.*

1 = YES 2 = NO

_____ 23. Have you sought counseling services at your college to address the impact of the race-based traumatic experiences?

_____ 24. Do you think that such counseling would be helpful?

_____ 25. If needed, do you have access to mental health care?

IV. Academic Achievement

_____26. What is your current GPA?

1= 2.00-2.50 2=2.51-3.00 3 =3.01-3.50 4 =3.51-4.00
5 = Not Applicable (first year of studies)

_____27. Have you ever been on academic probation while in college?
1 = YES 2 = NO

_____28. Do you think you will graduate on schedule from this college?
1 = YES 2 = NO 3 = NOT SURE

Thank you very much for your cooperation!

APPENDIX B

Qualitative Interview Narrative

1. How were you affected by the experience of racial profiling by law enforcement?
2. How were you affected by the experience of racial bias by high school teachers and college professors of another race?
3. How were you affected by the experience of racially motivated prejudice while being treated in a hospital?
4. How were you affected by the experience of discriminatory hiring practices while interviewing for jobs?
5. How were you affected by experiencing the racially motivated shootings in the South Carolina A.M.E. church?
6. How were you affected by the recent killings of Black males (Trayvon Martin, Michael Brown, Orlando Castillo, and Tamir Rice) by White officers?
7. How were you affected by the confederate flag being flown in certain states?
8. How were you affected by the violent acts committed towards Blacks by White supremacists and other hate groups?

Thank you very much for your cooperation!

APPENDIX C

IRB Approval Letter

CLARK ATLANTA UNIVERSITY
Institutional Review Board
Office of Sponsored Programs

October 4, 2018

Mr. Ondra Walker <Ondra.Walker@students.cau.edu>
School of Social Work
Clark Atlanta University
Atlanta, GA 30314

RE: The Study of the Prevalence of Race-Related Post Traumatic Stress Disorder Experiences Access to Treatment, and Impact On Academic Achievement Among African American College Students.

Principal Investigator(s): Ondra Walker

Human Subjects Code Number: HR2018-9-804-1

Dear Mr. Walker:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed your protocol and approved of it as exempt in accordance with 45 CFR 46.101(b)(2).

Your Protocol Approval Code is HR20189804-1/A
Type of Review: Expedited.

This permit will expire on October 4, 2019. Thereafter, continued approval is contingent upon the annual submission of a renewal form to this office.
The CAU IRB acknowledges your timely completion of the CITI IRB Training in Protection of Human Subjects – "Social and Behavioral Sciences Track".
Your CITI certification expires on September 5, 2020.

If you have any questions, please contact the IRB Office or Dr. Paul I. Musey, (404) 880-6337.

Sincerely:

Paul I. Musey, Ph.D.
Chair, IRB
Human Subjects Committee

223 James P. Brawley Drive, S.W. * ATLANTA, GA 30314-4391 * (404) 880-8000
Formed in 1988 by consolidation of Atlanta University, 1865 and Clark College, 1869

APPENDIX D

Informed Consent

The Study of the Prevalence of Race-Related Post Traumatic Stress Disorder Experiences, Access to Treatment, and Impact On Academic Achievement Among African American College Students

Researcher: Ondra Walker

Dissertation Chair: Dr. Richard Lyle

University IRB Chair: Dr. Paul Musey

Introduction: I am a doctoral student at Clark Atlanta University conducting a mixed methodology study in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Social Work. You are being asked to participate in this research study about your experiences as an African-American college student on your perceptions and experiences on race-related PTSD and how it affects your access to treatment and impact on your academic achievement. Please carefully read this document and ask any questions you may have before agreeing to take part in this study.

Purpose: The purpose of this mixed methods study is to examine the relationship between race-based trauma and PTSD among African Americans and to explore stressors related to PTSD. Participants in the study will be African American college students residing in the Metropolitan Atlanta area.

Procedures: If you agree to participate in the study, you will complete a questionnaire about the Study of the Prevalence of Race-Related Post Traumatic Stress Disorder Experiences, Access to Treatment, and Impact On Academic Achievement Among African American College Students. You may also be asked to participate in a face-to-face interview with the researcher. The interview questions will focus on your perceptions and feelings about race-related PTSD and how it may have affected you. Additionally, demographic data (gender, college level, parent's income, age group, marital status, and ethnicity) will be collected. The questionnaire will take approximately 8 minutes.The interview will take approximately 10 minutes and be located in a private space of your choice. The interviewer will hand record the interview. You will have the opportunity to review and clarify any of your responses. After verification, all files will be deleted/destroyed and any identifiable information on the records will be removed.

Risks and Benefits: There is no risk to the subjects. Participation in this study may not benefit the subjects personally. However, the researcher hopes to gain information about the subject's perceptions/experiences as an African-American college student as it relates to race-related Post Traumatic Stress Disorder regarding access to treatment and the impact it may have had on the subject's life as well as their academic career.

Voluntary Participation and Withdrawal: Being part of this study is voluntary. You may decline participation, refuse to answer any questions, or end the interview at any time without any consequence to you. Participation will not be shared with any other persons. Your participation or choice not to participate is voluntary and separate from your role as a student.

Confidentiality: Steps will be taken to protect you; identifiable information from the transcript will be removed, interview will be conducted in a private space, electronic documents will be stored in an encrypted file on a password-protected computer, and physical documents will be stored in separate files in a locked cabinet. There are no monetary benefits to you if you choose to participate in study. You will have the opportunity to obtain an electronic copy of the dissertation upon completion.

Contact Persons: If you have any questions about this research and its conduct, contact any of the following:

Researcher: Ondra Walker- ondra.walker@students.cau.edu

Dissertation Chair: Dr. Richard Lyle – rlyle@cau.edu

University IRB Chair: Dr. Paul Musey- pmusey@cau.edu

Signature: _____; I am indicating that I have read the information provided and give my consent to be a participant in the research. I understand that when I complete the electronic survey, I am indicating that I agreed to participate in this research project.

APPENDIX E

Letter of Request to Organization

Date: November 2, 2018

To: Jacquelyn E. Daniel
Reference Librarian

Dear Mrs. Daniel
My name is Ondra A. Walker. I am a Doctoral Candidate with Whitney M. Young Jr. School of Social Work at Clark Atlanta University. My dissertation topic: A Study of the Prevalence of Race-Related Post Traumatic Stress Disorder Experiences, Access to Treatment, and Impact on Academic Achievement Among African American College Students. I am requesting permission to disseminate a survey questionnaire to the students of your institution in an effort to collect data for my research. I appreciate your consideration in this matter.

Professionally Yours,
Rev. Ondra A. Walker, LMSW

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